THE CANADIAN NURSE

VOLUME 56 NUMBER 2

FEBRUARY 1960

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Between Ourselves

Despite the governmental programs for hospitalization in most provinces, or perhaps because of them, new impetus is being given to home care plans. Early in December last, a three-day institute convened in Ottawa to give leadership in the further development of this form of nursing service. A report of this institute is included in this issue.

Home care plan discussions have constituted a major part of the program of the national Committee on Nursing Service as its chairman, SISTER MARY FELICITAS, notes in her guest editorial. Born in Saskatchewan, Sister joined the Community of the Sisters of Providence of Kingston and received her professional training at Providence Hospital, Moose Jaw. She holds her bachelor's degree from the University of Ottawa, her master's from Catholic University, Washington, D.C., where she was awarded Phi Beta Kappa in recognition of her high level of scholarship. Director of nursing education of St. Mary's Hospital, Montreal, since 1945, Sister has been a member of the *Journal* Board since 1952. She represents the nursing sisterhoods of the province of Quebec on the CNA Executive Committee and is very active in her provincial association.

* * *

The twentieth century level of civilization is a far cry from the environment in which our remote and primitive ancestors existed. Excepting in such limited areas as the valley of the mighty Amazon river or a few of the isolated islands in Polynesia, mankind no longer is beset by such catastrophic perils that it has only two major methods of reacting — fight or flight. To permit a human being to respond instantaneously to an acute emergency, two closely associated systems functioned within his body: the endocrine glands that could eject needed substances directly into the blood stream, and the sympathetic nervous system to act as the coordinating mechanism.

Primitive man knew instinctively how to react. The physiological reason why he responded as he did was not known until modern medical research identified the individual parts of this complicated mechanism and discovered their various roles. None of us is concerned about the glandular processes until they get out of hand — either by functioning too actively and becoming "hyper," or by their failure to function properly when they are labeled "hypo."

Both hyperactivity and hypoactivity are included in the articles featured in this issue. How each responds to adequate medical and nursing care is discussed.

* * *

We have departed from our established practice of publishing the same article in the two languages this month. In our English edition, Miss CHRISTINE MACLEOD, president of the Manitoba Association of Hospital Auxiliaries describes the many and varied ways in which the ladies assist the hospitals in her province. Mme. MARGUERITE D. LAMOTHE, president of the Association des Auxiliaires des Hôpitaux de la Province de Québec has outlined the activities of the groups with which she is working.

* * *

From the points of view of both potential students and faculty members of other Canadian universities, one of the most exciting developments that has taken place within recent years has been the inauguration of the first post-baccalaureate program in nursing education at the University of Western Ontario, London. Such a step has been a cherished dream of Dean EDITH MCDOWELL for a long time. You can read her own proud story of what this progressive step means to all of us.

* * *

At the risk of "dating" ourselves, we recently counted back over the number of biennial conventions of the Canadian Nurses' Association we have attended. Our initiation was at the convention held in Regina in 1930. We missed the one in Saint John, N.B. in 1932. That was a depression year and, with small salaries, very few of us could attend. This year's convention in Halifax, will be the fifteenth we have been privileged to participate in. The last time the CNA met in Halifax was 1938. We were younger then, with no rheumatic joints! We travelled both ways — Vancouver to Halifax and return — by bus. It was then and still is a most economical as well as a comfortable way to see the countryside.

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Random Comments

Dear Editor:

Seeing there are so many nurses needed, I have been wondering if there could be refresher courses of a few days on a variety of subjects, i.e., obstetrics, surgical nursing, etc., where one could take only the subjects one is interested in. I myself would not be much interested in surgical nursing but others would be. I was always relieved when that part of my training was over. But I liked obstetrics very much. In fact, my private duty 25 years ago was almost exclusively looking after obstetrical patients in their homes.

I. J., Ontario

Dear Editor:

We have purchased one of your binders for our journals and find it very satisfactory. No definite decision has yet been reached but we are considering ordering more of them if they are still available. Are you planning to continue having them prepared every year?

M. R. T., Alberta

¶ *We have a considerable quantity of these economical binders on hand and shall order more as the supply drops so we welcome your requests for them. No year is stamped on any of them so you can label them as required.* Ed.

Dear Editor:

The Canadian Nurse has shown such growth and professional development these past years that I hesitate to suggest anything that has not been, or is not being, published. Knowing that very few of the younger members either receive or read the articles in the ICN Review, I wondered if you could and would copy that excellent article by Mary Helen Anderson, "The Greatest of These," which appeared in the *Review*.

G. M. F., British Columbia

¶ *Watch for this requested material soon.* Ed.

Dear Editor:

Each time another issue of the *Journal* comes in I think that I will write to let you know how much I enjoy it. I especially enjoyed the October issue for almost the entire number was articles from Quebec nurses. It is most encouraging to have nurses in so many parts of our country writing on such a variety of subjects.

J. S. W., Ontario

Dear Editor:

Regarding the article, "Why Judge Them?" in your November issue by Sister Ste Mechtilde — she had much of worth to say on the subject but she did not say this. While the powerful influence of alcohol is still being felt, why not make it the subject of a discussion? We realize what alcohol can do to the dignity of man.

J. M. W., British Columbia

The Canadian Broadcasting Corporation is presenting a series on nursing on Trans-Canada Matinee. The series can be heard on six consecutive Mondays from January 11 through February 15. Time is 2:30 P.M., E.S.T. but consult your local newspaper for times in other regions.

* * *

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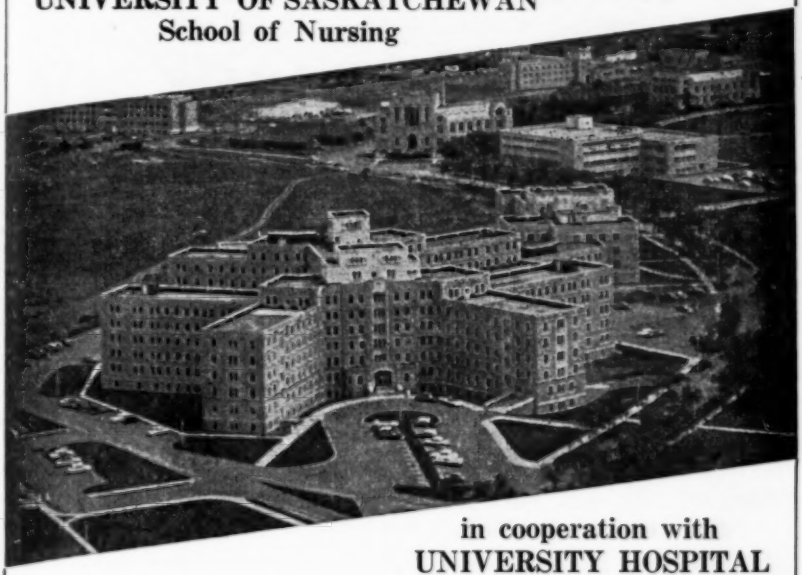

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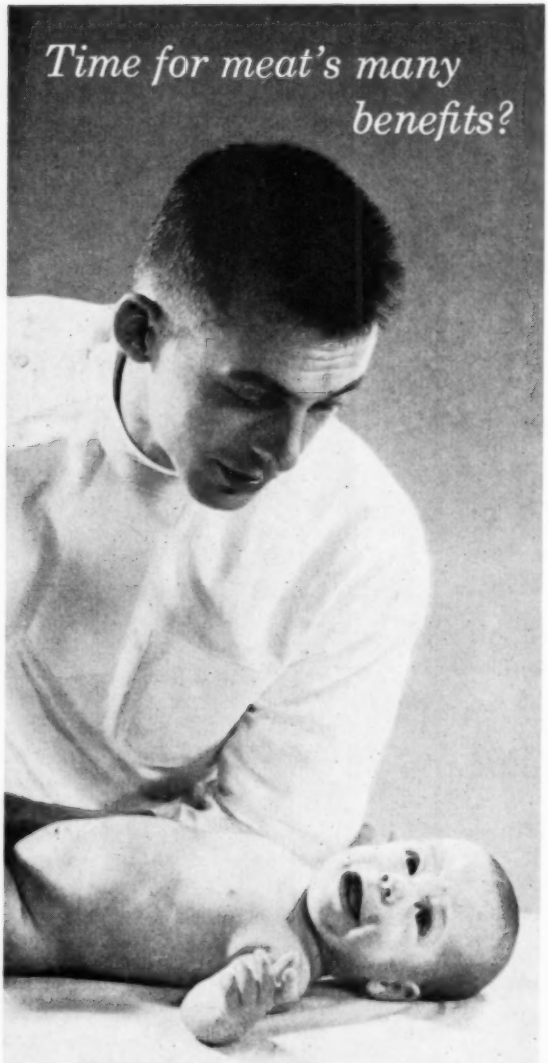

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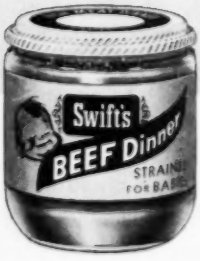

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 2

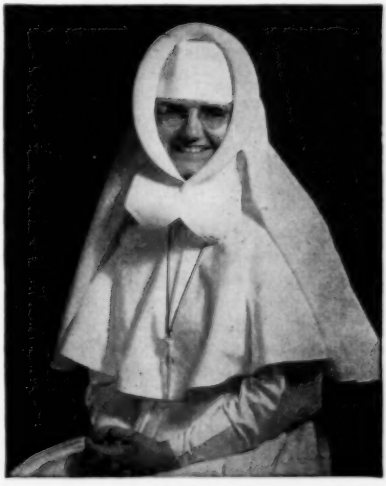
MONTREAL, FEBRUARY 1960

Nursing Service Developments

WHAT has been the business of your National Committees this biennium? Although each committee has its specific functions outlined in the By-laws of the Canadian Nurses' Association, all committees aim to assist our members through the formulation of national policies. By their study, or recommendation of studies, various facets of national nursing concern are presented to the Executive Committee which has responsibility for leadership in these areas. Periodically a committee undertakes the preparation of some material which is published because of its usefulness to the membership; to cite just two examples: the Public Relations Guide, and the Orientation Manual.

The Nursing Service Committee directs its attention to matters which promote high standards of nursing in Canada, and which will assist the nursing profession to meet problems of nursing service wherever they may exist. Several topics which come within its scope, have been deliberated by our committee. I have chosen to comment on two of these.

A few years ago, a study of head nurse activities was made under the auspices of the Research Division, Department of National Health and Welfare, Ottawa. This imposing document has been utilized in various ways



SISTER M. FELICITAS

and has been the subject of discussion among many nurses across the country. As a result of this widespread interest, the Committee on Nursing Service began preparation of a guide for head nurses. Four years ago, a special working party laid its foundation. During this biennium, frequent meetings of another such group completed the work. If approved by the Executive Committee, it should be available to all nurses at the June meeting. We hope it will be a valuable tool for all those engaged in the management of a nursing unit.

Home care programs, with their implications for nursing, have also received the attention of our committee. These are organized programs, with centralized responsibility for the administration and coordination of services to patients in their homes, which make provision for at least the minimum of medical, nursing and social services. Such programs may be hospital centered or community centered. Both types are found in Canada and the United States.

Historically, physicians have always provided care in the patient's home. Allied services have not always been available. In spite of attempts to give "comprehensive nursing care" which would embrace provision for all needs of the patient, such care is usually limited to that given within hospital walls. In a visiting nursing program, it is again confined to available facilities. Organized home care would attempt to bridge the gap by bringing together all forces, in a coordinated fashion, on behalf of the patient ill at home, thus extending the facilities of the hospital for such continuous care and for maximum rehabilitation. Whether the responsibility for integration is hospital based or community based, selectivity of patients is essential. It cannot be considered a substitute for inpatient facilities; patients should be placed on home care only when home care best meets their needs. It is necessary that those responsible for administration of the program, as well as the patient and the family, are jointly prepared to meet the needs of the patient.

Such a plan adds to the growing conviction that the hospital is a community service rather than a separate entity for the isolation of disease. It carries the implication that those who work in hospitals may have need to reconsider their role as members of the community in which they live. It is evident that the concept of nursing is broadening in response to the social changes occurring in our midst. The fact that home care plans under both these patterns have been inaugurated in certain areas of Canada and are under active consideration in others, should lead all nurses to review their activities as citizens as well as nurses.

SISTER MARY FELICITAS,
Chairman
CNA Committee on Nursing
Service

Dr. Casimir Grabowski, assistant professor of anatomy, University of Pittsburgh School of Medicine is investigating the effects that oxygen deficiency may have in producing congenital defects in the developing embryo. It is known that oxygen deficiency can produce congenital malformations in mice and chick embryos. When the oxygen concentration of the embryo is reduced in experimental studies gross defects such as cleft lip and palate, anomalies of the heart and great blood vessels and missing or defective extremities are seen to occur. Evidence indicates that oxygen deficiency will also produce malformations in the human embryo. The blood vessels within the embryo seem to be affected by the lack of oxygen and they, in turn, cause more obvious malformations.

Dr. Grabowski is systematically studying the way in which different periods of oxygen deficiency induce congenital malformations in the chick embryo and ways in which the effects of the deficiency can be counteracted. It is expected that both the amount of the deficiency and the stage of embryonic development at which the deficiency occurs will be important factors in the type of malformation which will take place.

Report, Easter Seal Research Foundation

* * *

In uplifting, get underneath. — GEORGE ADE

Diagnosis and Management of Adrenal Hyperfunction

W. I. Morse, M.D.

The study of the complexity of endocrine function has long been a "bug-bear" to the student of nursing. The picture of adrenal hyperfunction may become more clear as a result of the following presentation.

The metabolic ward of the Victoria General Hospital, Halifax, provides an example of effective teamwork between the physician and nurse. This close cooperation is very important for the investigation and treatment of endocrine and other metabolic disorders, as I will attempt to show by citing two examples of adrenal hyperfunction.

Before discussing these patients it would be helpful to note briefly the changes which may be expected from excessive secretion of the three major types of adrenal cortical hormones.

1. *Hydrocortisone* is probably the most important secretory product of the adrenal cortex and has a profound effect on the organic metabolism of the body. It stimulates the production of sugar from protein so that when present in excess one might expect an elevated blood sugar level. A large protein loss would be manifested by muscular wasting, weakening of the protein structure of bone and changes in the skin. Hydrocortisone also affects the distribution of body fat especially that around the face and on the trunk. This hormone seems to play a vital part in the response of the body to all types of stress such as injuries and surgical operations.

2. Another adrenal cortical hormone which is essential for health is called *aldosterone*. Among other things this hormone controls the amount of salt which the body retains under different circumstances and for this reason it is important in the maintenance of normal blood pressure and hydration.

3. The third group of hormones is called *adrenal androgens*, but these do not seem to be nearly so essential for health. When secreted in normal quantities they may be concerned with muscular development and the formation of new tissue. However, the excessive secretions of these hormones, occasionally observed in children or women, brings them to the attention of the physician because of the masculinizing effect which they engender. This effect is recognized by premature puberty in the male child and by changes in the body build, voice and clitoris in the female along with hair growth on the face, chest and lower abdomen.

The recognition of an excess or deficiency of some of these hormones is greatly facilitated by measuring their excretion rate or their metabolic products in the urine. These measurements can be very useful in evaluating adrenal function but only if a complete urine collection has been made over a carefully timed 24-hour period. If the specimen is incomplete because of an error on the part of the patient or the nurse it must be rejected. Experience has shown that specimens will be incomplete all too frequently on a busy general hospital ward. For this reason small metabolic wards have been established in many large general hospitals in order to collect urine and stool samples and to perform other specialized metabolic investigations.

Chemical analysis of the urine for its content of cortisone metabolites (17-hydroxycorticoids) is made along with an analysis for adrenal androgens (17-ketosteroids). The determination of aldosterone content involves a much more difficult analysis.

The physician can gain further information regarding adrenal function by injecting a hormone which stimulates the adrenals. This is known as adrenocorticotrophic hormone (ACTH). As might be expected this procedure normally increases the 17-

Dr. Morse is on the staff of the Victoria General Hospital, Halifax, N.S.

hydroxycorticoid and 17-ketosteroid levels in the urine. ACTH is secreted by the normal human pituitary gland in small amounts. Other information regarding adrenal function can be obtained by deliberately suppressing the pituitary ACTH output by the administration of hydrocortisone or one of the newer synthetic steroid hormones. If the 17-ketosteroid excretion fails to drop markedly during such a test an androgen-secreting tumor of the adrenal cortex or the ovary must be suspected.

This brief review of adrenal cortical physiology and the major tests for recognizing adrenal cortical dysfunction may help to clarify certain aspects of the following case reports.

Masculinizing Tumor

A 15-year-old girl had noticed an increase of facial hair one year before admission to the metabolic ward. This was followed by a deepening of the voice and a tendency to acne. On examination, it was noted that there was a fairly marked growth of facial hair and of coarse hair on the chest and abdomen. The clitoris was slightly enlarged but internal examination of the pelvis showed it was normal.

Twenty-four hour urine samples were collected and the 17-ketosteroid content was definitely increased although the 17-hydroxycorticoids were normal. She received Prednisone (a steroid closely related to hydrocortisone) for four days with the expectation that the 17-ketosteroid excretion would drop markedly. In this patient, however, no drop occurred. This made the presence of an adrenal tumor distinctly likely. Special x-rays were taken. These showed no definite abnormality although there was a slight suspicion of a mass in the right adrenal region. Both adrenal glands were subsequently removed by the urological surgeon and although they appeared normal on gross examination, it was considered not improbable that they were the source of the excessive androgen secretion. The ovaries could not be visualized at that time because flank incisions were considered necessary to get good adrenal gland exposure.

A few days after this operation the urinary excretion of 17-ketosteroids was again measured and found to be almost identical with the previous high value. This clearly indicated that the source of her excessive androgens had not been removed and that another operation was required. A few weeks later the patient's ovaries were examined through an abdominal incision and a tumor of the left ovary was removed.

During the postoperative period the 17-ketosteroid excretion was shown to be very low. This proved that the tumor had been the source of the excessive secretion of masculinizing hormone. The pathologist felt that this tumor had the appearance of adrenal tissue — obviously displaced adrenal tissue which had undergone neoplastic change. The patient has done well since her second operation and much of the excessive hair growth has now disappeared.

As a result of the removal of both adrenal glands this girl must have a small dose of cortisone or some related steroid each day in order to survive. During the first few days following both of her operations this cortisone was given intramuscularly because of the uncertainty of using the oral route at that time. The need for intramuscular cortisone or intravenous hydrocortisone is increased at such times.

The following incident demonstrates the importance of frequent observation by the nurse immediately following bilateral adrenalectomy. Fifteen hours following surgery it was noted by the nurse that the patient had a pulse rate of 140 per minute. The chart of the pulse and respirations had been carefully completed and indicated that this increase in pulse rate had occurred gradually during the previous few hours. The wound dressings had been checked and indicated no excessive blood loss at the site of the drains. The physician was notified and a larger dose of intravenous hydrocortisone was prescribed. This was followed by a reduction in pulse rate and general improvement in the patient's condition. The nurse's role in this incident prevented more serious acute adrenal insufficiency.

Bilateral Adrenal Hyperplasia

A 43-year-old woman was known to have had high blood pressure for seven years and had sustained a marked weight gain with fat accumulation on

the trunk and neck during the past five years. She complained of weakness, headaches and had had a cerebral vascular accident three months before admission. A growth of coarse hair had also become apparent on the face during the past five years suggesting increased adrenal androgen secretion. The blood pressure was 205/125. The fasting blood sugar level was increased.

The distribution of body fat, the hypertension and hyperglycemia suggested Cushing's syndrome although the muscle mass and radiological bone evaluation were not abnormal. The 24-hour 17-hydroxycorticoid excretion was definitely increased. This offered strong support for the diagnosis of excessive hydrocortisone secretion. The 17-ketosteroids were normal. Following intravenous infusion of ACTH the normally expected increase in 17-hydroxycorticoid and 17-ketosteroid levels occurred suggesting that the adrenal glands were hyperplastic rather than the site of a steroid-secreting carcinoma.

Both adrenal glands were exposed by the urological surgeon and were found to be slightly enlarged. Both glands were removed resulting in a marked drop in the urinary excretion of 17-hydroxycorticoids and 17-ketosteroids.

The patient now takes a carefully determined dose of cortisone and fluorohydrocortisone each day. She is maintaining a normal blood pressure and normal blood sugar concentration. The excessive hair growth on her face considerably improved. Her weight is down from 283 to 226 pounds on a reducing diet but this obviously leaves much to be desired.

Untreated Cushing's syndrome is often fatal and these patients stand the stress of operation poorly. The early postoperative course of this patient will demonstrate the close cooperation required between physician and nurse.

During the first 24 hours after bilateral adrenalectomy her systolic blood pressure could be maintained above 90 mm. only by continuous infusion of noradrenalin. A special nurse was assigned throughout this period and numerous visits by the physician were necessary to adjust fluid and hydrocortisone therapy. Two to four days later several episodes of dyspnea occurred. One of these episodes was due to atelectasis. This was undoubtedly the result of the pain associated with coughing and the obesity which made it extremely difficult to turn the patient. A portable chest x-ray was taken which proved of no diagnostic value. This pointed out the necessity of movement by the patient so as to clear the atelectasis. Further pulmonary collapse was avoided by frequent turning by the nurses and by assisting the patient during coughing. A few days later a severe episode of dyspnea was associated with evidence of pulmonary embolism. She survived this with the help of anticoagulant therapy but a few days later it had to be discontinued because of bleeding from both incisions. This patient illustrates the stormy postoperative course which many cases of Cushing's syndrome experience.

The chief purpose in relating the above case reports has been to demonstrate the team work required between physician and nurse in patients with adrenal hyperfunction. Any large general hospital is well advised to have a metabolic ward staffed by alert nurses with training and experience in the highly specialized procedures which this type of work involves.

A 24-page illustrated booklet entitled "Home Care of the Child with Rheumatic Fever" has been prepared especially for parents of youngsters for whom hospital treatment is either not advised or not available. It contains practical pointers on home nursing techniques and suggestions for dealing with the psychological and emotional problems that are likely to arise when a youngster is confined to bed for more than a week or two.

This new booklet is issued as a companion piece to "Have Fun . . . Get Well" a publication on recreational activities for the child who is confined to bed. Both are published by the American Heart Association, 44 East 23rd St., New York 10.

* * *

It is notorious that the memory strengthens as you lay burdens upon it, and becomes trustworthy as you trust it.

— De Quincey

Nursing Care in Adrenal Hyperfunction

JOYCE T. ELLIOTT

Nursing care of the patient with adrenal hyperfunction is interesting and challenging. Learning here is truly an ongoing process.

DURING the first eight years of its existence, our metabolic ward has housed a wide variety of patients. They come from two sources. Some are referred directly by the doctors of the metabolic ward staff, others from the wards of the main hospital. The latter are screened before admission to determine whether the condition is suitable for the special studies presently being done in the unit.

Diabetics are always on the ward, as well as patients who require assessment of thyroid function. Some receive radioactive iodine therapy for the treatment of hyperthyroidism. It has been fascinating to watch their progress. There have been many patients admitted for observation and adjustment of replacement therapy following hypophysectomy. This operation is done to alleviate the unhappy state of metastatic involvement of the bony structure in those who have had carcinoma of the breast. Many patients are admitted for assessment of adrenal function.

Shortly after the ward was opened a 13-year-old boy was admitted, who presented a typical textbook picture of Cushing's syndrome. A unilateral adrenalectomy was performed revealing a benign adrenal tumor. Jimmy was a very rewarding patient for within two years he had grown into a normal young person. Fat pads no longer hid his ears, the buffalo humps had disappeared from the back of his neck, and there was a marked decrease in the striae on the skin of his abdomen and extremities. The precocious sex interest that had been of such concern to his parents, and had been one of the main reasons for bringing him to the doctor's attention, was now notably modified.

Two years ago a lady was admitted who was remarkably cheerful when one considered her general appearance. She was of medium height, large frame, with a total body weight of 283 pounds. The obesity was centripetal, sparing the limbs, her face was moon-shaped and hirsute. There was a buffalo-type pad of fat on her back and intertrigo beneath both breasts. The mother of seven children, five years prior to admission she had had a hysterectomy. It was during these five years that her great weight gain had occurred. Hair growth on her chest, pubic area, axillae and legs had greatly increased. She shaved daily and was troubled by acne on her face and chest. Other complaints were shortness of breath with nocturnal dyspnea, palpitation, frequency and nocturia.

Following a bilateral adrenalectomy she was returned to the metabolic ward from the hospital recovery room, and placed in an oxygen tent. Intravenous apparatus was attached to both legs, permitting maintenance of blood pressure over 90 mm. systolic, by alternate administration of Solu-cortef and Levophed. On several occasions when a sudden drop in blood pressure occurred we had to raise the foot of the bed.

Immediately postoperatively her urinary output was small and highly concentrated. There were frequent episodes of rapid pulse and respirations with cold and clammy skin. Inflamed areas developed about the site of the Levophed infusion and did not respond well to an injection of Rogitine. She had a troublesome cough, pain about the operative areas and a definite tendency for the skin over the coccyx to break down. This was successfully prevented by the use of tincture of benzoin. Her oral intake was slow in reaching satisfactory fluid and caloric amounts. She developed a fondness for remaining in the oxygen tent longer than the doctors felt was warranted.

Few patients could have presented

Miss Elliott is on the staff of the Victoria General Hospital, Halifax, N.S.

a more definite picture of discomfort after a conscientious struggle had been made to make her comfortable. On being questioned she unfailingly stated that she did not feel at ease. She developed pain in the right leg which proved to be thrombophlebitis. Hot compresses were applied to both legs and eventually to the operative areas. Inability to retain oral cortisone necessitated the continuance of the intramuscular type. She was also given aminophylline, heparin and benadryl. She was able to sit up on the side of the bed on the ninth postoperative day. There were no further complications.

At regular intervals this patient has returned to the ward for re-assessment of her requirements for replacement therapy and for general recheck. Several unhappy family incidents have continued to complicate her obesity problem, and have perhaps prevented a successful response to operation.

The second patient for bilateral adrenalectomy was young and weighed 148 pounds.

Her postoperative course was remarkably uneventful with the exception of the instance that Dr. Morse has described. While commenting on the difference in the progress of the two patients, he explained that the boy with Cushing's syndrome had a stormy course because of the impairment of his general health by this condition.

The third patient returned to normal oral intake promptly. Oral cortisone was started on the second postoperative day. The next day she sat up in a chair and continued to increase her activity daily. She was discharged from hospital on the 13th day after operation.

On re-admission in four weeks she said that she felt that she was in much better health, but her hirsutism had increased. She remained on the unit until re-evaluation of her steroid levels was completed. She was then transferred to the main hospital where a left salphingoophorectomy was performed.

Now, her hirsutism is steadily decreasing and the control of her replacement therapy is very satisfactory.

Celiac Disease

HUBERT O'HANLEY, M.D.

There is as yet no satisfactory explanation for the development of celiac disease. However, our knowledge of the food factors involved in its occurrence has increased. This has given us the key to a means of control although not of cure.

CELIAC disease is essentially steatorrhea which is the result of malabsorption of fats from the intestinal contents due to changes produced in the physiological function of the intestinal mucosa by certain foods in a manner as yet not understood. The clinical picture presented by the patient with this disease varies according to its severity and duration. Many children have only prolonged or recurrent diarrhea without any significant effect on their general growth or development. Others are reduced to a state which is characterized by severe cachexia with loss of muscle and fat, a huge protuberant abdomen, marked anemia and weakness, and increased susceptibility to infection. The round red cheeks of these children in sharp contrast to their general emaciation is an intriguing facet of a disease that holds fascination for many who are interested in clinical research.

Diagnosis in the advanced case rarely presents difficulty. A history of prolonged diarrhea characterized by gruel-like stools and associated with body wasting and abdominal distention immediately indicates the condition. In infancy specific laboratory examina-

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tions may be necessary to differentiate fibrocystic disease of the pancreas from celiac disease. These examinations have become so accurate and simplified that determination of the specific disease is no longer very difficult. In older children laboratory tests may be employed, particularly in those who are not severely affected, to confirm the clinical diagnosis. These tests are based on poor absorption of fat so that the demonstration of increased amounts of fat in the stool remains of prime importance in diagnosis.

It has long been known that the malabsorption characteristic of celiac disease was related in some way to particular foods in the diet. For many years fats were believed to be the offending agents because of the increased amount of fat that appeared in the stool. Then starches were shown to be responsible for celiac disease in many children. In recent years protein in the form of the gluten fraction of wheat and rye has been shown to have a deleterious effect on the majority of celiac patients. Whatever the offending component of food, the manner in which it produces its ill effect is not understood. One researcher stated that very careful examination of the gastrointestinal tract at autopsy failed to reveal any abnormal histology. In recent years many attempts have been made to demonstrate abnormal pathology in celiac disease but as yet no definite correlation has been established. The pathophysiology of celiac disease remains unsolved.

The complications of celiac disease in addition to body wasting and general debility include a number of specific deficiencies related to the loss of fat in the stools. The fat soluble vitamins are excreted in large amounts and the patient may show lack of vitamin D and vitamin K especially. Concurrent with vitamin D deficiency is the loss of large amounts of calcium in the stool. Rickets and tetany are therefore frequently associated with prolonged celiac disease. Anemia is often marked. Plasma proteins may be reduced sufficiently to lead to edema. The general debilitated state makes these patients very vulnerable to infection and recurrent episodes are common.

The treatment of celiac disease may be simple or complicated. If gluten is the offending food, a gluten-free diet results in dramatic improvement in the child's health and remission of the disease complex. On occasion when a gluten-free diet does not have the expected results, other forms of dietary management are necessary. Sometimes considerable difficulty is encountered in selecting the proper foods for elimination. Starches in particular need careful evaluation in the diet of a child who does not respond to gluten-free foods. It also appears that fat may, on occasion, be the dietary factor needing restriction.

The essential thing is to achieve a diet that the child can tolerate and which also provides him with adequate intake for proper growth and development. His diet should be palatable, especially if marked anorexia characterizes his illness. Additional amounts of water-soluble vitamins are necessary adjuncts and calcium should be supplied generously. Anemia, if present, requires specific therapy. To bring a child from cachexia to robust health may require many months of controlled treatment. When this happy result is achieved, it may be inadvertently lost by reverting to a normal diet. This happens when the parents believe the child to be cured and no longer in need of restriction of diet after he has been clinically well for months. It is very important that the parents should be educated to realize that celiac disease is *never* cured but only held in remission by dietary control.

Those who have lost an infant are never, as it were, without an infant child. They are the only persons who, in one sense, retain it always. —LEIGH HUNT

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Has any reader ever found perfect accuracy in any newspaper account of any event of which he himself had inside knowledge?
— EDWARD LUCAS

* * *

To him who is in fear, everything rustles.
— SOCRATES

The Celiac Child's Diet

SISTER JOAN MARY, C.S.M., M.A.

Raising a child who has celiac disease presents subtle problems. Keeping to a rigid diet involves more for the mother than the mere exclusion of certain foods.

OVER a period of years numerous dietary plans have been proposed and used in the treatment of children with celiac disease. Invariably they depended on the elimination or restriction of starches and fats. Since 1950 one of the causes of celiac disease has been attributed to an intolerance to gluten (or gliaden) in wheat and rye with the starch fraction considered harmless. Many patients have responded to a gluten-free diet. However, a few still fail to thrive satisfactorily on this diet and require restriction of other foods such as potatoes, fats and foods high in residue.

The exclusion of wheat and rye flour eliminates bread, cake, pastry, gravy and soups thickened with flour, together with buns, biscuits, and other foods. Celiac patients react only to the protein in wheat (gluten) and can take wheat starch without harmful effects. Gluten is separated from wheat on a commercial basis and the product — pure wheat starch — can be readily obtained. It costs only slightly more than ordinary flour, and is used as a substitute. The bread, though quite palatable, is less easy to make than ordinary bread. It is crumbly and heavier because of the lack of the dough-making property of gluten. Angel cake and cookies can also be made with this flour.

The gluten-free diet is not difficult to give at home. The main problem is the presence of small quantities of wheat flour in a wide range of manufactured products not clearly of wheat origin, for example: ice cream, canned cream soups, canned meats, packaged puddings, mayonnaise, macaroni and spaghetti, as well as other foods of unknown origin. One child had a recurrence of symptoms by eating one serving of canned meat. The parents should have a list of the foods the child has to avoid as well as of those allowed. Apart from the total exclusion of wheat and rye gluten, the diet in many cases is normal.

Obviously, the cooperation of the parents is essential in caring for the celiac child. They must be persuaded to adhere to the diet rigidly as even a small amount of gluten is enough to bring on a recurrence of symptoms. One mother in speaking of her celiac child stated "If he ate the crumbs from the carving board, when I was cutting the home-made bread it was enough to bring on diarrhea."

Getting the child to accept a diet free from gluten requires weeks of unlimited patience and persuasion. All children as soon as they become conscious of the actions of adults and other children tend to imitate them. Consequently, they not only want to eat what they see adults eating but demand foods other children ask for, such as bread, cake and ice cream. One mother reported solving this problem by substituting those foods with lollipops and sherbet. Her child could eat both without difficulty and did not feel deprived of all sweets.

The parents' emotional attitude to the word *diet* has a great deal to do with their willingness to see that the diet order is carried out on an individual basis within prescribed limitations. Their psychological reaction will mirror the habitual pattern of response of the individual child. It must be remembered also that the appearance of food has a psychological effect on the celiac child as it has on any one. Everyone seems to relish food which is attractively prepared and served on colorful

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Sister Joan Mary, a staff member at Charlottetown Hospital, P.E.I., has recently completed the requirements for her master's degree at University of St. Louis, Mo. Her graduation thesis was on this topic.

dishes with an added garnish. Pleasant surroundings and cheerful company will do much to win the cooperation of the older child in accepting the foods allowed on the diet.

Dietary restriction may cause feelings of embarrassment in a celiac child who cannot accept foods others enjoy. The need for special foods along with some restriction of his activity, further contributes toward making a child feel different. To avoid unpleasant situations it may be helpful to limit parties. In this way the child is not faced with a variety of foods he cannot have and fatigue is also avoided by not partaking in play that causes over-exertion.

Social difficulties are also existent in carrying out the diet. One is that of ensuring a gluten-free lunch for a child who must take his lunch to school.

The following recipes are made with gluten-free flour:

Gluten-free Loaf

1⅞ cups gluten-free flour
4 tablespoons sugar
4 tablespoons butter or margarine
4 teaspoons baking powder
milk as required

Sift dry ingredients into a bowl. Rub in butter. Mix in enough milk to make a batter consistency. Mix lightly and pour into a greased tin. Bake in a quick oven for 10 minutes. Then reduce to a moderate heat for a further 30 minutes.

Angel Cake

4 eggs
¾ cups sugar (white)
½ teaspoon vanilla
¾ cups sifted flour (gluten-free)
1 teaspoon baking powder
¼ teaspoon salt
2 teaspoons lemon juice

Place mixing bowl over pan of hot water. Add eggs and sugar; beat until mixture is lukewarm. Remove from heat, then beat until the mixture resembles whipped cream. Add vanilla, Cool. Sift flour or wheat starch, then add baking powder and salt; sift again. Gradually fold dry ingredients into egg mixture, using spoon or wire whisk. Fold in lemon juice. Gently poor into ungreased pan — (9-inch tube pan). Bake in 350° F. oven 35-40 minutes, or until cake springs back when lightly touched with finger. Invert on rack 1 hour. Loosen sides of cake with a spatula; remove from pan.

Diabetes Mellitus

G. Greaves *and* Elizabeth Ward

Prescription for the diabetic — full life or mere existence? To understand is to cope, to fear is to fail.

Diabetes mellitus is a chronic disease of metabolism associated with an insufficient supply of insulin. Secreted by the beta cells of the ductless glands of the pancreas or islands of Langerhans, insulin is necessary for the metabolism of carbohydrates and therefore for fat metabolism.

The first step in carbohydrate metabolism is the conversion of the glucose that is not needed for immediate energy, into glycogen so that it may be put into temporary storage. For this conversion to take place the glucose must be transported through the cell membrane; one theory widely held today indicates that insulin in some way promotes this transportation. The process of conversion, called *glycogenesis* takes place largely in liver cells. It is to be noted that diabetic patients have very little liver glycogen.

The second step is *glycogenolysis*, the opposite of glycogenesis, is the reconversion of glycogen to glucose and its transportation outward through

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the cell membrane. Insulin appears to be necessary for glycogenolysis also. Two other substances influence this process, both by stimulation of it. They are: epinephrine which is present in excess amounts during times of stress, and the hyperglycemic factor, glucagon from the alpha cells of the islands of Langerhans.

Insulin and thyroid hormone both exert control over the rate of carbohydrate catabolism — insulin because it promotes glucose transport into cells so that it is available for oxidation and thyroid because it accelerates the oxidation reaction.

Insufficiency of insulin may be due to fibrosis of the islands of Langerhans or an actual decrease in the number of these structures.

Incidence and Prevention

Diabetes is chiefly a disease of older people, the incidence increasing steadily with age and reaching a peak between the years of 65 and 75. The incidence of diabetes is increasing for three reasons:

1. Diabetics live so much longer now that the disease may be controlled.
2. Diabetics are having so much more children.
3. The average duration of life of the entire population is lengthening.

Diabetes is hereditary, with one person in four inheriting the tendency. A diabetic should therefore not marry another diabetic and should avoid marrying into a diabetic family. The older the age of the patient when diabetes is diagnosed the milder the disease will be.

The disease is more common in people who are overweight. Above the age of 30, 80 to 90 per cent of potential diabetics are overweight before they develop the disease. The mother who gives birth to an infant weighing 12 pounds or more stands a 100 per cent chance of later becoming a diabetic herself.

Diagnosis and Management

The onset of diabetes is usually insidious. The patient may experience no symptoms whatsoever or he may report any or all of the classical triad: polyphagia, polyuria, polydipsia. There may be an accompanying weight-loss, weakness, drowsiness, vague aches and pains, dryness of the skin and mucous membrane. The diagnosis is usually made on the findings of hyperglycemia and glycosuria. The objectives of management are as follows:

1. To compensate for the metabolic insufficiency by the administration of insulin, or an oral hypoglycemic agent, by diet or by a combination of drugs and diet.
2. To attain and maintain an ideal body weight.
3. To prevent complications.

The following two nursing care studies illustrate the way in which these objectives were met for individual patients, at different stages of their diabetes.

Infection as a Complication of Diabetes

The Patient

Mr. Thomas was admitted to hospital with a diagnosis of "diabetes out of balance." He was a 39-year-old man who had lost a great deal of weight over the past few months. Despite the fact that he was very uncomfortable, he was cheerful. He had a wonderful outlook on life.

The fact that he was a diabetic had changed his way of life very little and the special care that he had to take because of his illness fitted in naturally to his daily living. He told me that he follows his diet carefully and when he goes out to dinner, either he or his wife supervise the type and quantity of food served to him. Fortunately his diet has not been too much of a hardship for him as he does not like sweet things. He feels that this is nature's way of keeping him from eating high caloric foods. Occasionally he uses saccharin in his tea or coffee.

He did not recall ever having experienced diabetic coma, but occasionally when he had had too much exercise he had experienced mild shock. He carries lumps of sugar at all times, to be taken if he feels weak or begins to perspire freely. He has thus prevented serious insulin shock, but is aware that this may occur and therefore carries a diabetic identification card.

He has been very careful to rotate the sites of injection and no lumps appears on his arms or legs. He also realizes that special care to his feet is essential.

In order to understand his illness more fully Mr. Thomas has read several books on diabetes mellitus, and while in hospital never passed up an opportunity to learn more about his condition.

During my conversations with him he told me that there was a history of diabetes in his family. Although his father did not have the disease, some of his father's brothers and sisters did. Mr. Thomas has six children including two sets of twins. His eldest child is a daughter of 14. The children are checked every six months by the family physician. Both he and his wife, who also thoroughly understands the disease, are watchful for signs and symptoms in their children.

Past History

This is the fifth time that Mr. Thomas has been hospitalized for control of his diabetes. When the condition was first diagnosed it was regulated with diet. After losing 40 pounds he remained free of glycosuria for six months, but thereafter it was necessary for him to take protamine zinc insulin. Two years later he came to hospital because of painful swelling of both legs, which was attributed to thrombophlebitis. He improved with treatment only to return the following year with an infected ulcer on his right leg. A culture isolated Staphylococcus *pyogenes*. Five days later he was discharged to be treated further at home.

Present Illness

Mr. Thomas suddenly developed diarrhea. It lasted for about three days and was followed by an attack of "influenza." Before he was completely well again he developed moderately severe pain in the region of the right ischial tuberosity. The pain came in spasms, was not relieved by aspirin and only partially relieved by the application of heat. Two weeks later he was admitted.

When the doctor talked to Mr. Thomas he discovered that the patient had visited his mother in California the year before because she had become ill with pulmonary tuberculosis. A chest x-ray was taken which proved negative. An intradermal tuberculin test was done using strength 1:10,000. The results were suspicious so another was done with strength 1:1000. This test proved negative. An x-ray of his right hip showed no definite lesion but his elevated sedimentation rate and white blood count and a temperature which remained between 100° and 102° F, indicated a hidden infection.

The white blood count normal is 5,000 - 9,000. On admission it was 14,700, ten days later 21,450. Sedimentation rate normal is 0-10 per hour. Mr. Thomas' was 105 per hour on admission and remained high.

A diagnosis of rectal abscess proved negative on sigmoidoscopic examination. The final diagnosis was "diabetes with severe infection of unknown etiology or site."

Medication and Treatment

The infection caused Mr. Thomas' diabetes to be "thrown out of balance." His Clinitest read + 4. His fasting blood sugar was as high as 257 per cu. mm. of blood, normal being 80-120. On admission he was given a 3,000-calorie diet and 50 units of protamine zinc insulin once daily. (This is a long-acting insulin with onset of action in 4 - 6 hours, duration 24 - 36 hours.) As his Clinitest continued to be + 4 he was given a 2800-calories diet and 55 units of isophane insulin (N.P.H.) (This type of insulin is made from zinc insulin crystals modified by protamine. It acts within 1 - 2 hours and lasts for 28 - 30 hours.) Repeated Clinitests indicated + 4 with the Acitest strongly positive. Protamine zinc insulin was tried again, 80 units daily, but it did not bring the diabetes under control. He was then given 35 units of plain insulin q. 6. h. For the first time during his hospitalization his Clinitest dropped to + 1. (Plain insulin, also known as unmodified or crystalline, is short-acting with an onset of 20 - 30 minutes and a duration of 6 - 8 hours.) Some time later Mr. Thomas was changed to protamine zinc insulin, 70 units daily. As the infection subsided the amount of insulin his body required decreased. On discharge he was receiving 45 units of PZI. His Clinitest and Acitest both remained negative.

The pain in Mr. Thomas' hip became almost unbearable at times. It was not relieved by acetophen compound with codeine gr. ½, so he was given Demerol 100 mg. q.3.h. p.r.n. (Demerol, or meperidine hydrochloride, resembles codeine in its analgesic qualities. It is not as potent a hypnotic as morphine.) It only partially relieved the pain.

Until the infection disappeared the diabetes was almost impossible to control. Mr. Thomas was given chloromycetin 500 mg. q.i.d. for five days. It had apparently done nothing to control the infection and was discontinued because the doctor felt that an antibiotic might prevent the abscess from "coming to a head." Six days later, the patient was given Signemycin 500 mg. q.i.d. (This is a broad-spectrum anti-microbial combination of oxytetracyline and oleandomycin.) After 11 days of administration his temperature returned to normal. Seven days later when it was discontinued his temperature remained normal.

Hot compresses did not relieve the pain, and although Mr. Thomas gained some relief while he was in a hot bath, the effort of getting in and out of his bed and the tub was exhausting. For this reason he refused the baths more often than he accepted them.

Nursing Care

Mr. Thomas had been a diabetic for quite a few years and knew a great deal about his condition. He was very aware of the importance of caring for his feet. Each day they were washed with warm soapy water, dried carefully and rubbed with cocoa butter.

Because of pain and a general feeling of malaise, it was sometimes impossible for Mr. Thomas to eat his meals. The missing calories were made up with juices. Sometimes he had to be coaxed to take them.

One afternoon he stated that he felt weak. His skin was grey and moist, he was drowsy and very apprehensive. His pulse was 120 and full. He was immediately given a glass of orange juice containing three teaspoonfuls of sugar. Insulin shock was prevented but this incident proved that although his Clinitest was + 4 it was possible for him to have an insulin reaction.

Mr. Thomas' blood sugar was high so it was necessary to watch for diabetic acidosis. Fortunately it did not occur.

During Mr. Thomas' hospitalization there was an influenza epidemic in the city. The hospital was closed to visitors, so he was very lonely for his wife and family. At times when his morale was very low, I made a point of staying near him to chat about his family.

Rehabilitation

Mr. Thomas needed no new teaching. The lessons he learned from the doctors and nurses by their actions and discussions with him served to reinforce his knowledge of the disease and to reassure him that he was caring for himself in the best way possible. The present illness emphasized for my patient and for me, the importance of the prevention of infections in the diabetic patient.

The Problem of Diabetic Control

The Patient as a Person

Mr. Henry, aged 43, had his own business as a plaster contractor. Six years ago he decided he would like to engage in some work where he could be of greater service to his fellowmen. Despite the fact he had had only grade X schooling, he enrolled in a two-year course in psychiatric nursing. Completing this preparation he has been employed as a psychiatric nurse up to the time of his present hospitalization.

Past History

Mr. Henry's diabetes had been diagnosed five years earlier when he was admitted to hospital for a hemorrhoidectomy. Twenty minutes prior to the operation a 2 + sugar was discovered. An immediate repeat urinalysis showed only a trace of sugar since the patient had had no breakfast. His fasting blood sugar was 180 mg. per cent, normal 80 - 120 mg. per cent. Despite these factors the operation was performed. His postoperative course was satisfactory.

Mr. Henry recalled that there had been an increase in his urinary volume and fluid intake in the past year. He had also noticed that he was more diaphoretic on less exertion. He was discharged on five units of crystalline insulin twice a day and a diabetic diet of 2000 calories. The doctor's objective was "to carry the patient on the minimum requirement of regular insulin and diet, with a view to discontinuing the insulin if possible." For the next two years there was little trouble controlling the disease due to the patient's intelligent care of himself. He read many books and articles on the subject of diabetes and, because of his training, thoroughly understood his condition.

Four years ago when he was admitted for dental surgery, the doctor decided to reassess Mr. Henry's diabetes.

On admission his fasting blood sugar was 188 mg. per cent. After breakfast it was 460 mg. per cent. Postoperatively he received crystalline insulin and intravenous glucose. During his hospital stay experimentation was made with isophane insulin (NPH) but this did not control the diabetes properly. He was discharged on a regulation dose of 45 units of protamine zinc insulin and a 2500-calorie diet. At this time his urine varied from a 3 + to 4 + Clinitest with a negative acetone.

Present Illness

Early last fall, Mr. Henry began to have trouble controlling his diabetes. He had his blood sugar tested once a week and the results were usually above normal. His diet had been increased to 2700 calories. His dosage of insulin was increased by 20 units so that he was receiving 65 units of PZI a day. He noticed that he was drinking excessive amounts of water. He kept a jug of water at his bedside at night because his mouth "began to feel like parchment." Because of the excessive fluid intake, he had abdominal cramps which increased in severity as the polydipsia became worse. A gastric analysis was done to rule out the possibility of an ulcer. The results showed that he had only a minute amount of gastric juice. He was given hydrochloric acid to take before each meal. At this time his Clinitests showed a positive reaction most of the time. He had made a practice of testing his urine three times a week when his diabetes was regulated, and three times a day if there were any positive Clinitests. Besides the 65 units of PZI once daily he took 5 units of crystalline for every 3 + Clinitest and 10 units for every 4 +. The severity of his diabetes increased until he was taking as much as 20 to 30 extra units of insulin a day. A month before his admission to hospital, Mr. Henry had two slight insulin reactions. His blood sugar was consistently high and he was having no negative Clinitests. It was in this condition that he was admitted.

He adjusted very quickly to the hospital routine and at the end of the first evening was chatting companionably with the other patients in the ward. Because the doctor had asked him to be up and about, he passed the time by walking around the ward and getting acquainted with the other patients. After two days, when he felt more "at home," he began helping with jobs around the ward. Towards the end of his hospital stay he was allowed to do the Clinitests for himself as well as for other diabetic patients.

On admission Mr. Henry's temperature was 98° F., his pulse was 72, regular and of good quality and his respirations were 20. Four hours later he had an insulin reaction for which orange juice was given with good effect.

An 1800-calorie diet was ordered. After having had a 2700-calorie diet it was learned that he was very hungry. He had been used to eating in the evenings at home so arrangements were made with the diet kitchen to provide him with evening nourishment.

The chest x-ray showed no evidence of a parenchymatous lesion but the hilar shadows and lung markings were heavy.

His fasting blood sugar was 346 mg. per cent on his first morning in hospital. From this initial high it gradually lowered until at the time of his discharge two weeks later it was down to 123 mg. per cent.

On the fourth day of hospitalization his insulin was increased to 20 units before every meal, three times a day. He was weighed and it was found that he had lost 17 pounds in three months. He had a slight insulin reaction for which two glasses of orange juice with added sugar were given with good effect. He described the symptoms of his reaction as a "tingling" feeling in the tips of his fingers, a "hollow sensation in his stomach" and diaphoresis. His Clinitests were still positive for sugar.

During his sixth hospital day, Mr. Henry experienced three reactions, one in the early afternoon, the second in the late afternoon and the third in the evening. He was given four ounces of orange juice and one teaspoon of sugar, each time. The patient was nervous, tense and unable to sleep in the early part of the evening. At midnight a sedative was given and he slept well.

Before breakfast the following morning the doctor was notified of the previous day's happenings. He decreased the insulin to 15 units before breakfast. Later it was reduced to 15 units before

dinner and supper with 20 units before breakfast. The diet was increased to 2100 calories, the extra calories to be divided between breakfast and supper. The patient had one more reaction. Mr. Henry stated that these reactions were much more severe than any he had had previously.

Two days later, the crystalline insulin was adjusted as follows: before breakfast 20 units; before lunch 15 units; before supper 10 units. Mr. Henry had two more slight reactions. On the ninth day his insulin was changed to 45 units of NPH once daily before breakfast. On the eleventh day, his diet was increased to 2300 calories. As the mid-afternoon and evening are the times during which reactions may occur when NPH is being used, the extra 200 calories were divided between dinner and the evening nourishment. His Clinitests were now negative almost every time and his blood sugar was 123 mg. per cent. The diabetes seemed to come under control once the patient was started on a course of NPH insulin.

He was instructed to continue with his 2300-calorie diet and 45 units of NPH insulin once daily at home.

Teaching

No specific teaching was required as the patient understood the problems of diabetics. Mr. Henry had mentioned that he had been having trouble with his eyes. He noticed that when reading for moderate lengths of time his vision had begun to blur. Because of the incidence of diabetic retinitis, it was suggested that he visit an ophthalmologist as soon as possible.

Summary

It can readily be seen from these two nursing care studies that the diabetic patient can lead a happy and productive life. Both patients had a good understanding of their condition and a positive attitude toward the disease despite frequent hospitalizations. They have learned to cope with an incurable disease and how to prevent complications. These studies may make helpful reading for the new diabetic who is frightened or the old diabetic who is discouraged.

Juvenile Diabetes

SISTER MARIE DE ST. MARC

A student nurse teaches a new diabetic about her disease and its control.

YVONNE, a girl of 17, came to hospital. The second oldest in a family of ten, she was orphaned at 14, and became the mother of the house.

One could notice the early maturity. Her flushed appearance and nervous gestures were indicative of extreme fatigue. Her temperature was 99° F, pulse 88, respirations 24, blood pressure 112/60 and weight 102 pounds.

She complained of symptoms which exactly characterize those of the diabetic: a sensation of hunger, excessive thirst, blurred vision, frequent large amounts of urine, loss of energy and weight, general malaise, etc. The details were carefully charted. After a careful examination, the doctor wrote emergency orders and asked to be called as soon as the reports came back.

After receiving the reports the doctor visited Yvonne again. He told her that she was diabetic, that she would have to be on a strict diet and take insulin injections. He told her that if she cooperated he would soon have the illness under control. She had nothing to worry about, the prognosis was excellent especially because she was an intelligent patient who would cooperate with her doctor. Before departing he asked the nurse to be responsible for teaching this young girl about her illness.

Sister Marie de St. Marc was a student at the Hôtel Dieu Hospital in Montreal when this paper was written.

Doctor's orders:

Blood sugar daily
Save all urine
Clinitest q.i.d.
Acitest q.i.d.
Measured diet
Crystalline insulin before meals as follows:

sugar in urine	*insulin*
2 +	16 units
1½ +	8 units
1 +	6 units
½-¾+	4 units

N.P.H. insulin 10 units every morning.

N.P.H. insulin has an onset of action of two hours and duration of 18-24 hours. It aids greatly in the control of diabetes.

The next day before lunch, Yvonne had a visit from her family. I noticed that they brought her a lovely box of chocolates. A difficult battle was being waged within the patient. A conflict arose between her desire to satisfy her tastes and her desire to control her diabetes. She told herself it was hopeless to have to follow a diet all her life. I explained to her that diabetes in itself was not serious but that there are complications. I explained them to her as simply as possible. Nothing more was necessary to convince my patient that she must, at all costs, be faithful to the insulin and the diet.

The patient learned that diabetes is due to an insufficiency of the secretion of insulin from the pancreas. This insufficiency causes metabolic disturbances. Too much sugar is liberated from the liver and so it appears in the urine.

Further education of the patient included teaching her how to use Clinitest. The method employed is:

mix five drops of urine and ten drops of water in a test tube. A Clinitest tablet is then added and you wait until the boiling has ceased. The color is then compared to the color chart and insulin given according to the results. The Acitest is even more simple. A bit of powder, about the size of a pea, is put on a piece of white paper and two drops of urine are added to it with an eye dropper. With the help of a color chart the presence or lack of acetone can be determined.

Soon, Yvonne was able to carry out her tests without supervision. The 24-hour specimen permitted determination of total output and the total amount of sugar during the same time. The blood sugar determines the level of sugar in the blood. Acetone indicates the presence of toxic acids. Insulin controls the blood sugar.

As the days passed, this young girl became the object of frequent and attentive visits by her doctor, in whom she placed complete confidence. She had faith in his orders and with the cooperation of her nurse carried them out to the letter.

During the first few days there was little change in the tests. After five days there was marked improvement in her health, a drop in her blood sugar and the quantity of sugar in her urine. In two weeks the diabetes was under control. The doctor told her that she could be discharged as soon as she could give her own injections. That was all she needed to make her decision. All that remained to do was to teach her to prepare her injections of insulin.

I explained how the syringe was marked . . . 40 units and 80 units. I emphasized the importance of checking the concentration on the bottle and using the corresponding scale on the syringe. Sterilize the top of the bottle with alcohol. Draw into the syringue the same amount of air as the insulin prescribed. Shake the bottle then force the air from the syringe into it. Withdraw the number of units required, checking again carefully. Clean the skin on the arm or the anterior surface of the thigh with alcohol, being careful not to inject it too closely to former sites.

The patient was soon able to give herself injections with ease. She learned to sterilize the syringe by boiling it for ten minutes, then wrapping it in a sterile wrapper.

I advised my patient to take extreme care of the skin of her feet, to take a warm bath daily and to dry well between her toes; to be careful not to cut her toe nails too short; never to touch corns, and to prevent them by wearing shoes that are not too tight; to avoid injuries, and treat them immediately they occur; above all, never to forget to take her insulin.

The doctor gave Yvonne a diabetic

identification card with instructions always to carry it. It read as follows:

> I am a diabetic and take insulin. If anyone finds me ill, unconscious or behaving in a strange manner, put a cube of sugar or a candy between my teeth or make me drink a glass of orange juice slowly. If, within 15 minutes I am not better, take me to the nearest hospital or notify my doctor.
>
> My name is ..... Tel. .....
> Address .....
> My doctor is .....
> Address ..... Tel. ....

She was also given a diet sheet. It bears repeating: "The diabetic who accepts and understands has already overcome half of the problem. With diabetes, a grain of wisdom is worth the treasure, health."

You Are What You Eat

DOROTHY COMEAU

Have you a low threshold of fatigue? Do you have problems with your budget? Try examining your physical fitness and your food dollar against the criteria that follow.

MALNUTRITION is the condition brought about by the improper assimilation of food. Without food, our very life could not be sustained and without *good* food and a sound diet physical fitness cannot be attained.

> The difference between what you are and what you would like to be may largely be a matter of the kinds of food you are eating. Foods are body-building materials and the kind of body one has depends mainly on the kind of food eaten.[1]

One needs not only sufficient food, but a varied diet, because there are some nutrients which require the presence of others in order to be fully used, in somewhat the same way as chemical reactions require catalysts.

The amount of food required for an average day's work, in terms of calories, ranges from 2800 in the colder countries such as Norway, down to 2200 in warmer countries such as the Philippines. In the five years preceding World War II, about 38 per cent of the world's population had to subsist on less than 2200 calories per day. In the past twenty years this has risen to 59.5 per cent; in other words, "almost three people out of every five in the world today are hungry."[2] This is partly due to the fact that only 8 per cent of the earth is under cultivation — 8 per cent of the world's surface in crops to feed two and one half billion people! Even more startling is the fact that "one-third of mankind consumes three-fourths of the world's food."

Miss Comeau is a student in the degree program, X-ray Technology, of Mount Saint Vincent College, Halifax, N.S.

Causes of Malnutrition

> In spite of all the efforts of international organizations . . . in spite of increased production, food supplies are just keeping pace with the growing population . . . Even in countries where calorie levels are adequate, diets do not contain enough protective foods . . . To combat the inequality in the world's food supplies the Food and Agriculture Organization (of United Nations), in 1943, established food consumption targets representing food supplies which, from the nutritional standpoint, are quantitatively and qualitatively adequate for everybody . . . The production of cereals would have to be increased by 50 per cent, the production of meats by 90 per cent, of milk and dairy products by 125 per cent, vegetable oils 125 per cent, fruits and vegetables 300 per cent.[1]

We in Canada have an abundant food supply, being one of the ten

countries having the highest calorie level in the world. Nevertheless, evidence of malnutrition exists among both rich and poor. In some cities where dietary studies have been made, it has been estimated that one-fifth of the families are not getting the right kind of food or the right amount.

> In 1955, 86 Canadians died of malnutrition due to vitamin deficiencies. Three of these died of scurvy, two of beri-beri, five of rickets, four of osteomalacia and 72 of other B and C deficiencies. Yet, in 1945, only 44 deaths from malnutrition were reported, even after six years of war. And in 1935, there were 72 deaths. All these deaths are, of course, totally unnecessary, but after all, they are not so many in a population of 16 million. Far more important are the many thousands of Canadians suffering from debilitating forms of malnutrition.[2]

According to a nutrition survey covering all age groups in 14 different areas of Canada, made over a 10-year period, 14% of the people were anemic due to lack of iron, protein and various vitamins; 7% had rickets; 10% had sore itchy eyes, sore lips and sore tongue due to a lack of milk products, liver, meat and eggs; 3% had night blindness, poor skin and lowered resistance due to lack of vitamin A; 16% had protein deficiency from lack of sufficient meat, milk, fish; 3% of males and 4% of females were 10% underweight; 1% of males and 2.5% females were 10% or more overweight; 0.2% lacked niacin (vitamin B) which is found in potatoes, cereals and meats; these showed digestive disturbances, skin eruptions, mental depression and pellagra. "Apart from these people who show well defined results of nutritional deficiencies, 12 to 50 per cent of Canadians surveyed were endangering their health through eating much less than the amounts of protective foods recommended in Canada's Food Rules."

All surveys in every area have shown that some people do not make use of the foods available. The problems most frequently encountered were:

> insufficient use of vitamin D by school children; inadequate use of milk for calcium and riboflavin; low intake of fruits and vegetables as sources of vitamin C; over-use of sweet foods and fats which destroy appetite for more nutritious foods.

Three main factors govern eating habits: intellectual, psychological and economic. Since Canada has an excellent food supply available, and most families have a reasonable income, supplemented by Family Allowance, faults in Canadian's eating habits do not seem to be due to an economic factor, at least in the majority of cases. In spite of the many opportunities for adult education, people are still quite ignorant of the relative values of different foods, proper selection and preparation of foods, not only to retain their vitamin values but to present them in an appetizing form. How many vegetables are cooked too long, and their juices poured down the drain! Another form of ignorance is the belief in fads and fallacies, for example, "skipping breakfast helps you reduce," "only babies need cod liver oil," "potatoes are fattening."

Psychological factors, attitudes towards food, can cause anything from constant nibbling to complete rejection of food. Teenagers congregate at the soda fountain in search of companionship; dissatisfied persons sometimes use food as a substitute for other objects that they crave; hard-working businessmen may be too fatigued at mealtime to eat properly. Ethnic groups who are accustomed to certain foods in their native lands may not find dishes to their liking here, and fail to supply the deficiency from the foods that are plentiful. Finally, there are the timid folk who will not try anything new, and the people who "eat solely to maintain life" and are not interested in food. A balanced personality shows here as in all aspects of life — one's attitudes towards food may be quite revealing.

The economic factor regarding foods in Canada seems to be compounded of ignorance and attitudes. A good many people spend money on soft drinks, candy and other fancy items, so-called "empty calories"; or they buy the most expensive cuts of meat when they could, with skill and training, make the cheaper cuts equally appetizing. Nutritious and appetizing food for Canadians is well within the average budget. The trouble is that so many fail to see that "ounce for

ounce, milk is cheaper than soft drinks raisins cheaper than chocolate bars, peanut butter cheaper than jam",[1] and that there are countless exchanges or substitutions that can be made in menus and recipes that will preserve or even increase their food value while decreasing the cost of a meal.

Better nutrition can come only when people are interested in knowing how to get the best possible diet for what they have to spend. In most areas there are agencies of one kind or another capable of providing such information, for example, the extension services of universities and colleges, public health and nutrition clinics, child welfare and health centers. Safeguarding our food supply and keeping the food costs within the purchasing power of the low-income groups should be a part of our national defense program, in the building of a healthy nation.

Nutrition is necessarily one of our major life-time pre-occupations. What we eat will either contribute to our life's happiness and effectiveness or will condemn us to live below our potential in both health and enjoyment.

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The Profession and the University

EDITH M. MCDOWELL, M.A.

Canada's first Master's degree course in nursing has been launched.

DURING the next decade, an increasing number of Canadian university schools of nursing will offer advanced educational programs. For many years, the Canadian Nurses' Association and many individual nurses as well as non-nurses, have been asking why our university schools of nursing did not offer post-baccalaureate degrees. Our American colleagues, to whom we are so much indebted, have asked the same question.

This year, for the first time, two post-baccalaureate students are registered at the University of Western Ontario School of Nursing. They plan to complete the academic requirements of a two-year program leading to a Master's degree in nursing. This program is one of the projects made possible by the W. K. Kellogg Foundation's five-year grant to the school of nursing. In the early development of this program, the school proposes to focus attention upon the field of administration, particularly administration of nursing services.

The process of defining the content of advanced educational programs is not without its problems. One difficulty arises within the universities where nursing is a comparative new-

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EDITH M. MCDOWELL

comer. The faculties of the liberal arts, of law, medicine and theology have all had a very much older association. Historically, many universities had their origins in the development of one or other of these faculties. Programs of nursing education did not make their appearance in Canadian universities until 1920. The selection and sequence of educational content of all programs, the academic standards to be maintained, the degrees to be conferred are subject to approval by university senates. Faculties of Schools of Nursing have to face these questions:

> Does nursing have its own content? What is this content?
>
> How should the content be selected and in what sequence should it be given to meet senate requirements at the Baccalaureate, Master and Doctoral levels of academic achievement?

The difficulties in planning university curricula are not lightened by the conflicting views of our profession concerning the art of nursing. Inconsistencies exist between our definition of the nature of that art and our active practice of it. Do we not have the degree of freedom that a profession requires in order to bring our aspirations into closer alignment with our practice? Does the failure lie in our educational programs or are administrative patterns in the practice field such that many nurses are frustrated in their attempts to apply the art of nursing as they believe it should be applied?

An analysis of the formulations concerning the nature of nursing in order to discover implications for education and practice, reveals that nursing is a synthesis. The content is derived from many fields of study that fall mainly into three categories:

1. spiritual studies
2. humanistic studies
3. the natural philosophies, that is, the sciences.

Take away any one of the three and the art of nursing is impoverished and incomplete, both in its education and practice.

That we have been concerned with the nursing situation is evidenced by the frequency with which certain phrases have grown into our professional literature in recent years:

> the nurse never nurses less than the whole patient . . . (Surely a blinding flash of the obvious!)
>
> comprehensive nursing care . . . total care needs . . .
>
> patients as people . . . interpersonal relationships in nursing . . . the person in the body . . . nurse-patient relationships . . . the nurse does not nurse pathology . . . she works with people — and a host of others.

If these expressions represent what is so obvious to us in the practice of nursing, is it possible that our current need to use them is symptomatic of some deeper lying pathology? Concerning man's spiritual needs in our society, there is not a little confusion and great questing for certitude. Between the humanistic studies and the natural sciences, there is a wide chasm across which human voices cannot be heard clearly. If we were to chart what appears to be a "pecking" order, the natural sciences would seem to have leadership prestige. This state of affairs creates many difficulties to all of the helping professions.

The difficulties presented thus far make their impact upon our progress in planning for advanced educational content. These difficulties could be very challenging to the nursing profession and are insurmountable only to a profession that does not attempt to see its situation clearly. Of the more than 60,000 practising nurses in Canada, how many are making an effort to see our professional situation clearly? How many of these cut short their own general education in order to enter hospital schools? How many of these closed their professional education with the attainment of nurse registration? Do they realize that through their practice the general public (and this includes other professional groups) derives the materials from which it builds the nurse-image in our society? Need we be surprised that the public appears bewildered when we use the expression "nurse education" but seems to understand us only too well when we speak of "nurse training"?

The nursing profession constitutes the largest single group of health workers throughout the world. Our immediate concern as a profession is with the health of the people of Canada. For too long a time we have per-

mitted public attention to focus on *numbers* and *quantity*, rather than on *quality* of health work.

If our basic education is too narrowly technical;

if we stress the natural sciences and exclude spiritual and humanistic understandings;

if the art of nursing is not practised at a high level in the patient care field where the student learns;

if we do not have well prepared teachers and administrators;

if administrative practices at all levels of responsibility are outmoded

then the quality of health care for the people of Canada is threatened.

As they have since 1920, employing agencies will turn increasingly to university schools of nursing for specially prepared nurses to fill positions of teaching, supervision, public health nursing and all levels of administrative responsibility. With the continuing expansion of health services, the demand will continue. Notwithstanding our attempts to increase undergraduate enrolment and the numbers of auxiliary workers, it should not be difficult to see that an increase in the numbers of students and of auxiliary workers, as well as the constant coming and going of general staff nurses will continue to strain our administrative and supervisory resources. This is the point at which our professional burden is most serious and difficult.

Is there any way in which we can help a larger percentage of our membership to accept the need for more advanced educational preparation in order to assist with the heavy burdens now carried by women in all leadership positions within our health agencies? What we are able to accomplish through university programs is contingent upon the levels of professional aspiration entertained by our practising members.

Shortages: Nurses or Nursing?

MARGUERITE KAKOSH, Ph.D.

What kind of nursing are we practicing in our hospitals today? When we think about it, that is, about ourselves, are we satisfied with what we see, hear, feel and do?

IT IS CONSTANTLY asserted that there is a shortage of nurses. The administrator cannot find enough and if he could his budget could not stand the strain. The doctor would like more nurses. The patient would like more professional nursing care. One study in the United States showed that patients received only 18 minutes of professional nursing care in an eight-hour period. It is apparent that the more education the nurse has, the higher her salary becomes and the further she moves from the bedside. The director of nursing service wants safe and adequate nursing care. She has by far the largest budget in the hospital. How much nursing care does the nursing service dollar buy? Where is the rest going? And the nurse, she is the unhappiest of all! She wants to spend more time with patients. She feels that "her duties are calculated to keep her from the bedside."

Fundamentally we want to nurse. If we had all the time we wanted would we be there at the bedside? Would the care be of a different character or quality or would it be the same? If we wanted to and if we had unity of purpose, we could learn to nurse *differently*.

Dr. Kakosh, who is an associate professor at the College of Nursing of Rutgers University, New Jersey, gave this address at the annual meeting of the Association of Nurses of the Province of Quebec.

The Practising Nurse

Systematic study of the *actual practice* of the professional worker is neces-

sary to secure improvement. The profession has not done this, neither have schools of nursing. What changes that have come about have come through nursing education. If one looks at the history of graduate programs it is evident that their educational objective has not been *practice*. It is regrettable that there are so few opportunities for the preparation of specialists in nursing *practice*. Can a nurse really teach if she has not had on an advanced level the course content she is going to teach?

Patient care has not had true professional quality. There are only elements of professionalism in it. Why? First, there is limited supervision in clinical areas on completion of the basic course. Second, there is little or no opportunity for the student or graduate to observe professional nursing care. The supervisor and head nurse must be able to practice above the level we now have in the basic course. There is a direct correlation between the quality of care which will be given and that which a supervisor is herself able to practice.

Actual nursing care of patients counts so little in remuneration, status, prestige etc. Bedside care seems so much less important than the work of the head nurse or supervisor. "I'm just a staff nurse" is a common remark. "Today I was an aide. I did all the work that an aide does — gave baths, dressed and fed patients, assisted them into wheelchair . . ." Was there really any difference in the practice of the aide and the nurse? Perhaps there is little reason to value it any more highly. Well-prepared skillful practitioners are paid the same as any who have put on a uniform for the first time. Until we are *able* and *enabled* to practice that quality of care that has inherent in it a growing source of satisfaction, we cannot expect respect for it.

Do we know *what* we are educating nurses for? Is my care the same as that given by the auxiliary? If there is no difference then the *profession* of nursing will die and only the *occupation* of nursing will continue to exist!

What difference will the quality of the care make? Will it make a difference?

Short term curative care is typical of what is commonly given in our hospitals today. It is *hospital-routine* and *procedure* centered. The nurse is kindly, well-intentioned and efficient; she approaches the nursing problem in terms of getting the *work done*. This care is considered to be of good quality by present standards.

A "gooder" type of care is possible — long term and rehabilitative. The nurse makes the *patient* the central focus. She brings to the nursing problem a deeper understanding of the roles of science; social and psychological, as well as physical and biological. This type of nursing does not imply a different definition but a broader application. The meshing of these sciences gives an increased depth and penetration of meaning to the practice of nursing. There is an understanding of the human being in order to help *him* to plan *his* way of carrying out treatment at *his* rate of growth, and to fit into *his* way of living.

This type of *practice* depends on the nurse's understanding and use of herself. Each nurse selects only those things which have meaning for her. To the extent that we can accept these concepts we will effect change — change in nurse practitioners.

> When one is a stranger to oneself then one is estranged from others too. If one is out of touch with oneself, then one cannot touch others.
>
> — ANNE LINDBERGH

Bibliography on Cancer for Nurses, U.S. Public Health Service Publication, No. 687, has just been released. It includes lists of books, pamphlets, annotated audiovisual materials, teaching aids, such as prosthetic devices and other equipment for care of cancer patients and annotated references on cancer of specific sites and nursing aspects of cancer. Available from: Superintendent of Documents, Government Printing Office, Washington, D.C., at 20 cents per copy.

* * *

The constant interchange of those thousand little courtesies which imperceptibly sweeten life, has a happy effect upon the features, and spreads a mellow evening charm over the wrinkles of old age.

— WASHINGTON IRVING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Seminar on Learning

An international seminar on "Learning to Investigate Nursing Problems" is being held in Delhi, India, this month. Thirty nurses from 15 countries will attend. The staff of the Florence Nightingale Education Division of ICN is organizing this seminar which will be financed by income from the Trust Fund of the Florence Nightingale International Foundation, supplemented by a grant from the Rockefeller Foundation.

During the last ten years nurses have, either by themselves or with other professional people, made great strides in systematic studies and scientific investigations of nursing problems. The experience gained will be drawn upon to help participants in the seminar to select those nursing problems which should be solved through research and those which can be solved by other measures. There will be both lectures and group work during the seminar. For the latter, small groups will work intensively on specific problems chosen by the participants themselves, so that the experience they gain will be highly relevant to their own current nursing problems.

Among problems which may be studied are: methods of ensuring the continuity in the community of the patient's nursing care after discharge from hospital; and how research on this subject can be assisted through home visits. Various research techniques will be studied as well as how the methods used in the social sciences can be adapted to nursing research.

Dr. CLARA HARDIN, sociologist and anthropologist and executive director, American Nurses' Foundation is chief consultant for this seminar. Assisting will be Dr. RENA BOYLE, chief, Nursing Research and Consultation Branch, Division of Nursing Resources, Public Health Services, USA Department of Health, Education and Welfare, and Professor J. H. F. BROTHERSTON, Usher Institute, Edinburgh, Scotland, representing the public health field.

National Office Staff

Miss JUSTINE DELMOTTE joined the staff of National Office December 7, 1959, as assistant to the general secretary. Miss Delmotte is secretary of the Public Relations Committee besides assisting in the overall administration of National Office. Her broad experience in nursing — both hospital and public health and her fluency in four languages, will enable her to play an important part in CNA work. She is warmly welcomed by us all.

Emergency Health Services Conference

On November 16-18, 1959, the President represented the Association at this national conference. Miss Helen Mussallem, representing nursing education and the General Secretary also attended as members of the Defence Medical Dental Services Advisory Board.

This conference brought together representatives of government and voluntary organizations who are concerned with problems involved in Emergency Health Services.

One hundred and five persons attended this meeting — a Minister of Health, Deputy Ministers, nurses, physicians, medical officers, armed service personnel, dentists and representatives of Canadian Medical, Canadian Hospital, Canadian Nurses, Red Cross, St. John's Ambulance Associations.

The main theme of the conference was coordination of services. Emphasis was also placed on "Self Help."

A cabinet committee has been set up and is the ultimate authority. A new committee has been established called Emergency Measures Organization—"EMO." The secretary of EMO is a member of the cabinet committee. EMO has two branches — one for emergency government services, the other, public services.

The Armed Services will be assigned certain activities but by no means the entire program.

A mass education program on a national basis is being planned. The objective is to have each individual informed, prepared to take care of himself and fit into the total program in the event of an emergency.

The President of CNA, speaking on television at the conference, said:

> Members of the CNA have always supported programs to improve the health and welfare of Canadian citizens. They will not lag behind in this regard.

The Order of St. John of Jerusalem

In October, the General Secretary was appointed to the Priory-Council of the Order of St. John of Jerusalem and represented the CNA at the meeting of the Grand Priory held in Ottawa, October 22. In conjunction with this, the General Secretary, as CNA representative, attended an Investiture at Government House, when Miss EVELYN PEPPER, RRC and Lieutenant Commander MARY NESBITT, were made Serving Sisters of the Priory of Canada of the Most Venerable Order of the Hospital of St. John of Jerusalem.

International Visitor

Mrs. MARGUERITE MENDES-HAMILTON of Ministry of Health, Kingston, Jamaica, has been awarded a WHO scholarship for three months' study in United States and Canada.

Mrs. Mendes-Hamilton holds the position of public health nursing supervisor for South Eastern Jamaica. Plans are forging ahead in Jamaica's Ministry of Health for the integration of public health, hospital and clinical services. It is in preparation for the implementation of these plans that Mrs. Mendes-Hamilton is visiting the provinces of Eastern Canada this month. The CNA extends a welcome to one of Jamaica's nurse leaders.

Film Preview

A new film in color entitled "Hospital Sepsis — a Communicable Disease" produced under the supervision of Dr. Carl W. Walter by Johnson & Johnson Limited was screened in Ottawa through the courtesy of the National Film Board.

It clearly describes the hazards involved in spreading infection through routine hospital procedures, and suggests methods of control. This film is recommended not only for professional personnel, but for all those involved with hospital housekeeping and maintenance of the hospital plant.

Curriculum Workshop

Forty-seven Canadian nurse educators registered at the Curriculum Workshop held in Ottawa, November 23-25, 1959, and organized by the CNA Committee on Nursing Education. This workshop was a preliminary step towards the preparation of a National Guide for Curriculum Development. Miss FLORENCE ELLIOTT, director, Study on Cost of Nursing Education, National League for Nursing, formerly director of Curriculum Conference Project, National League for Nursing, was coordinator and consultant. Through formal lectures, informal discussions and group work concepts of nursing and their implications in the development of a curriculum were discussed.

National Committee Meetings

CNA National Committees on Nursing Service and Nursing Education held their annual meetings in Ottawa in November 1959. Topics discussed at the meeting of the Committee on Nursing Service were job satisfaction, turnover of staff and social needs of nurses; home care plans and implications for nursing in hospital insurance plans. A draft copy of a "Guide for Head Nurses in Hospitals" was reviewed. This guide will be presented to the Executive Committee for approval this month. **Please watch this column for notification of its publication.**

Discussion during the meeting of

the Committee on Nursing Education centered around the educational programs for the registered nurse and the assistant nurse; philosophy, aims and objectives of basic nursing education diploma programs and the establishment of Canadian criteria for the evaluation of schools of nursing in Canada. The report of the Curriculum Workshop was discussed and further plans were made toward the development of a national curriculum guide.

Convention Personality

The preparations required for a General Meeting of the Canadian Nurses' Association involve a staggering amount of work for the nurses of the hostess province and city.

DOROTHY GILL

A sudden, even if very temporary rise in population within the convention city amounting to hundreds of people calls for months of planning if they are to be fed and housed comfortably. Auditorium space must be found; various social and recreational activities must be planned to provide a welcome break in a busy week; provision must be made for welcoming delegates and directing them on their way as each bus, train or plane arrival brings its complement of visitors. These and a horde of other details, down to providing information about the best place to get a fresh "hair-do," come within the scope of the Arrangements Committee.

The chairman of this committee requires, among other qualities, efficiency, endurance, and a sense of humor. **Dorothy Rosamond Gill** fulfills these requirements admirably. A graduate of Victoria General Hospital, Halifax with postgraduate preparation in teaching and supervision from the School for Graduate Nurses, McGill University and in psychiatric nursing from the University of Toronto, Miss Gill is supervisor in psychiatric nursing at V.G.H. She has taken a very active part in the work of professional organizations as president of her alumnae association; secretary and president of the Halifax Branch, RNANS; recording secretary and member of the public relations and nominating committees, RNANS. She can be counted upon to give the most capable leadership possible in helping to make this one of the best conventions ever.

New Diploma Course

The School of Nursing, Dalhousie University, Halifax has announced the establishment of a new diploma course in nursing service administration for head nurses, supervisors, and junior administrators in hospitals and public health agencies.

This is a general course extending over a period of approximately nine months. Only nurses who have had at least two years of graduate professional experience in a junior executive position will be admitted. The approximate cost will be $350.

Further information may be obtained from Miss E. A. Electa MacLennan, Director.

Nursing Profiles

We are pleased to extend special greetings this month to **Justine Marie-Rose Delmotte** who has joined the staff of National Office as assistant to the General Secretary. Born in the United States, and educated in Nova Scotia, Miss Delmotte is a graduate of the Royal Victoria Hospital, Montreal, with postgraduate education in public health nursing at the School for Graduate Nurses, McGill University, Montreal.

(Paul Horsdal)

JUSTINE DELMOTTE

She has had extensive experience in nursing on an international level beginning with her wartime service, 1942-45, as Captain (N/S) in the South African Military Nursing Service in Africa and Italy. In 1945 she joined UNRRA and IRO, working as an area nurse and then as a zone nurse in Germany and Austria. In 1948 she returned to Canada for a year of postgraduate study and subsequently joined the City Health Department of Montreal for a brief period. In 1950 the lure of faraway places resulted in an appointment with the World Health Organization and led to successive duty periods in Thailand, Cambodia and Morocco. Miss Delmotte returned to Canada again in 1958 and prior to her present appointment was a nursing counsellor with the Department of National Health and Welfare, Civil Service Health Division.

Fluent in four languages and with her rich background of nursing experience, Miss Delmotte will have much to contribute in her new position. Nurses are moving about from country to country in increasing numbers and with a freedom unknown just a few years ago. National Office is called upon to arrange for study tours and official visits for a growing number of overseas visitors each year. Apart from this group are the girls who seek employment in our hospitals and who bring with them problems in relation to registration and professional preparation. Her colleagues in National Office and the staffs of our provincial associations will welcome the expert advice and guidance that Miss Delmotte can undoubtedly offer. Canadian nurses can well be proud of the fact that one of their members has contributed so much to international nursing, and pleased that her skill and experience have been placed at the service of our own national association.

A little over a year ago **Emily R. Groenewald** left Montreal to take up her duties as assistant director of nursing at the DVA Hospital, Lancaster, New Brunswick. Recently she was appointed director of nursing there.

Miss Groenewald received her preliminary education in South Africa. She is a graduate

EMILY R. GROENEWALD

of Women's College Hospital, Toronto and received her diploma in teaching and supervision at McGill School for Graduate Nurses, Montreal.

Much of her professional career has been devoted to nursing education — as an instructor, Guelph General Hospital; medical supervisor, Children's Memorial Hospital (now Montreal Children's Hospital); nursing arts instructor, Winnipeg General Hospital; educational assistant, DVA Hospital, Ste. Anne de Bellevue, P.Q.; and director, Montreal Central School for Nursing Assistants, Queen Mary Veteran's Hospital, Montreal.

Miss Groenewald has been active in professional associations throughout her career. She is an enthusiastic follower of Montreal "Alouettes" and "Les Canadiens" and enjoys music, reading, travel and the theatre.

(L. Ford)

LENORE DUGGAN

Lenore Duggan who has been appointed professor of health education at St. Joseph's Teachers' College, Montreal, is the first nurse in the province of Quebec to hold such a position.

A graduate of St. Mary's Hospital, Montreal in 1949, Miss Duggan engaged in postgraduate study at the School for Graduate Nurses, McGill University, specializing in teaching and supervision in medical and surgical nursing. In 1958 she was appointed assistant director of her school of nursing.

We extend our good wishes and congratulations to her in this new venture.

ISABEL T. COLVIN

Isabel T. Colvin has been appointed associate director of nursing service at Regina General Hospital where she has served for the past several years as assistant night supervisor 1950-52 and obstetrical supervisor 1953-59. Since her graduation from R.G.H. in 1950, Miss Colvin has also completed requirements for her Bachelor of Nursing degree from the School for Graduate Nurses, McGill University. She has taken an active interest in the affairs of her provincial association and has served as secretary of the Regina chapter and as chairman of the Committee on Nursing Service.

Expendable plastic oxygen masks, designed to provide maximum patient comfort, are now made of a special non-toxic green vinyl that gently conforms to the face. They remain soft and pliable in use, and can be trimmed with shears to conform to unusual facial features. The masks are used with standard oxygen connecting tubes or with large-bore tubing, and are sold with breathing bags for high concentrations of oxygen.

For further information write to: National Cylinder Gas Division, Chemetron Corporation, Chicago.

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Medicine, the only profession that labors incessantly to destroy the reason for its own existence. —JAMES BRYCE

Manitoba Women's Hospital Auxiliaries Association

CHRISTINA MACLEOD

Hospitals serve the community but in Manitoba it is a two-way process. The zeal and hard work of women in their "leisure" time can contribute in large measure to the health of a community.

THE above title is quite a mouthful. It is also quite a handful to direct its workings in these days. This provincial association came into being on November 1, 1946. Aids had functioned, more or less, for 60 years wherever hospitals were established though they were few and far apart. In 1941 Dr. Buck of the American Public Health Association was requested to make a survey of provincial health needs. He made recommendations to the Manitoba Welfare Supervisory Board regarding the need for more hospitals and an increased bed capacity. Since that time hospitals have mushroomed all over the province.

The Hon. Paul Martin, former Minister of Health of the federal government, said:

> We are on the threshold of a new conception of hospital care. An administrative course is now being worked out by a Canadian Hospital Council Committee for a larger field of work throughout Canada and auxiliaries will enter into the picture more than ever before.

He was speaking at an organizational meeting of the National Council of Hospital Auxiliaries of Canada in Ottawa on May 29, 1951. The "larger field of work" was the increased numbers of hospitals mentioned previously.

A women's auxiliary is important to a hospital because the women of a community can do many things for a hospital that no one else can do. It is a truism to say that a hospital can not achieve its aims unless the public understands those aims and the means by which they may be accomplished. Unless it has the esteem and the support of the citizens of the community, the hospital can not function adequately. No matter what the population of your city, town or village or the total membership of your auxiliary, the members of the latter will exert an influence in proportion to their number, their enthusiasm and their intelligent appreciation of the hospital's problems. It is also a truism that the auxiliary member or volunteer who is well-versed in the activities of her hospital can tell its story better than the paid employee. To sell the hospital story takes ingenuity, energy and a deeply grounded belief in the value of the work. It also requires leadership.

The auxiliary's leaders have the duty of helping a group of community women choose activities and problems that are within the power and resources of the organization to pursue effectively. The group needs to feel that what it does is significant enough, important enough, difficult enough and necessary enough to challenge its thinking, talents and effort. Moreover the group must be able to make progress in its action, to carry out its program and reach its goals in an effective and controlled manner. It must feel and know that it is needed and fully appreciated.

Confidential information about individual members of a group belongs only to the members and their leaders. Personal information should be used only to assist in the leadership role and should never be released for common gossip.

The following excerpt is from an

Miss Macleod formerly a director of nursing of Brandon General Hospital, is the president of the Manitoba Women's Auxiliaries Association. In preparing this article the author drew some of her material from the auxiliaries suggested reference list.

address given by Mr. G. R. Rosenfeld, administrator of the Victoria General Hospital, Winnipeg. He was discussing the continuing and increasing need for auxiliaries.

> The humanitarian aspects of the care of the sick and injured in the hospital is the guiding principle which has served as a beacon to the women's hospital auxiliaries throughout the province of Manitoba and the world. It has not flickered or faltered, nor has the color changed. The money raised by the women's auxiliaries has done much to assist in the purchase of equipment and supplies for the care of the sick and injured. The public relations established through an informed and understanding women's auxiliary is the soundest foundation for a good hospital-community relationship. This serves to guarantee hospital financial security and permits the auxiliaries, through their volunteer services and fund-raising activities, to elevate the level of hospital care in the province of Manitoba. Hospitals can be understood best by and explained to the community most effectively through women's auxiliaries.

Public relations are discussed so much nowadays that we forget that each one of us is responsible for them every day. *What* we do or say or *where* we do or say it makes the difference between good and bad relationships. Let us ever be watchful in this respect.

From the beginning our provincial motto has been "Know your Hospital." The auxiliaries are proud of their hospitals. They want them to live and prosper. Judge Milton George of Morden, Manitoba, who is steeped in hospital work and recognized as an authority well beyond his native community said this of auxiliaries: "Voluntary women workers have kept hospitals from closing, particularly during the stressful years of the late thirties." He was living in a dried-out area of the province at that time and knew the situation well. "Those women who caught the vision and passed it on made an enduring contribution to those who are following in their steps." There was no director of volunteers then — it was really not feasible in eight-bed hospitals!

When visiting auxiliaries, guilds and aids throughout the province, one is struck with the perseverance it takes to keep on creating new projects. There

St. Agnes Guild Shop

must be careful planning to avoid duplication and to select proper launching times. As an example of a novel idea, one of the province's newspapers recently ran this headline: "Pilot Mound Bachelors are *Taxed* to Get Hospital a Sewing Machine." The women are continually coming up with new "gimmicks" and stimulating healthy competition. Often these are most amusing and unusual.

(Bill Rose)

The Volunteer and the Patient

Many of the women who make up the auxiliaries are grandmothers — but such youthful ones! Often they have had years of experience in church activities before turning their talents to hospital work. This places wonderful human resources for new direction and leadership at the disposal of the organization. The efforts of these women in public relations result in a well-informed community.

At the moment there are 73 auxiliaries in the province of Manitoba with more to be organized. Their value cannot be measured in dollars and cents. They have played their part in hospital building projects, preparing linens and obtaining necessary equipment for new units. They have assisted in student recruitment, arranged for loans for prospective nursing students. Their support has been given to local cancer campaigns, to the Red Cross home nursing courses designed to help relieve shortage of nursing service. Their achievements have really been too numerous to mention.

The following description of the work of the auxiliaries in four of our hospitals will serve to emphasize the importance of their role:

During the past five years, voluntary services provided to one of our large general hospitals — the Winnipeg General Hospital — by the White Cross Guild have totalled 70,025 hours. This would have an economic value of approximately $52,500. In addition the Guild provided the hospital with cash gifts amounting to $26,866. At present, their resources are being directed towards research work.

The guilds that serve The Children's Hospital of Winnipeg have raised an average of $25,000 per year during the past five years. In 1957 when the hospital residence was nearing completion, the six organizations undertook to provide the funds required for furnishing it. A total amount of $41,000 was acquired for this purpose. Now their resources are being directed to research.

Arranging flowers

The Princess Elizabeth Hospital Guild serves three hospitals for the chronically ill — the Princess Elizabeth, the King George and the King Edward. The Guild had pledged itself to provide the patients with friendship, comfort for body and mind, and to assist the hospitals in every possible way. They have surely kept their pledge! To the chronically ill, the women of the Guild are eyes, ears, hands and feet. When the polio epidemic produced an emergency situation, the Guild responded whole-heartedly to the need for assistance. The members arranged to assist with the feeding of helpless patients so that professional staff might be relieved for

other duties. Many other patient comforts have been made possible as well. The Guild has provided the hospitals with paraplegic chairs, crutches, wheelchairs, physiotherapy and public address equipment, and furnishings for the new hydrotherapy unit. One other most commendable project has been the fund set aside for the benefit of patients who are studying in order to become self-supporting.

At Steinbach, Manitoba in 1938 eight women formed an Aid that now numbers almost 500 members. They are the hardest working group of women that one could meet. During the past five years they have given the hospital more than $12,000 in cash but triple that amount in linens, fruit, vegetables and other produce. The store-room looks like a supermarket.

The work done by the members of these volunteer organizations is vast. Without their help, our hospitals and their patients would be much poorer not only materially but spiritually.

Patient Care at Home

Home care programs have been discussed, planned and in some areas, tried. This is a report of a conference on Home Care; what it is, why we need it, how it could be instituted, and what implications it has for Canadians — patients, their families and the medical and allied services which they use.

THE Canadian Nurses' Association recently sponsored a conference in Ottawa on Home Care Plans. In a general introduction to this subject Miss Eli Magnussen gave some answers to current pressing problems. Invited to Ottawa by Miss Dorothy Percy, chief nursing consultant, Department of National Health and Welfare, Miss Magnussen, who is a nursing consultant with WHO and chief nurse of the Danish Ministry of Health, spent two and a half days at the VON Blackburn House as a resource person to the conference. Some of her comments follow:

Although there is an ever-increasing number of hospital beds, the demand continues to exceed the supply. Because of a broader philosophy which states that every person should benefit from advances in medicine, there has been a rationalization regarding those who require less technical or long-term care. Are nursing homes the answer?

The psychological effects of long institutionalization are mental disturbances and broken homes. When a patient is cared for at home a cooperative development takes place there. Having a patient to look after can often gather the family together.

Because there is a marked increase in the number of older people in our society there is also a proportionate increase in chronic and long-term illness. We live longer and we live longer with our diseases.

At the present time Denmark has a population of four and a half million.

	1959	1980
Over 60	624,000	945,000
In nursing homes	54,000	81,000
Confined to bed or wheelchairs	12,000	18,000

If these patients are to be cared for at home what are their needs?

Domestic — homemaker service such as, shopping, cooking, serving, etc. In Denmark, a homemaker is prescribed by the doctor for one to two weeks. For patients who are elderly or disabled another group called "home helps" meets long-term needs.

Social — entertainment and occupational activities through cooperative planning with professions other than medical and nursing e.g. occupational therapy, social service etc.

Medical and nursing — family doctor, nurse, and physiotherapist.

Who will evaluate the needs? Some patients will only need parts of the service. Who will administer the system? One method is a hospital-based system. This is an extension of hospital

services into the home. Nursing service can emanate from the hospital or the hospital can buy nursing service. A second method is a community-based system with administration being carried out by government health service.

The inauguration of a home care plan and its successful functioning have two important requisites — (a) inclusion of the philosophy of home care in basic education in medicine and nursing; and (b) cooperation with other professions. Without cooperation the plan will fail.

Following Miss Magnussen's introduction to the topic there was a symposium entitled "Roles and Relationships in Home Care Plans." Those who participated were:

Dr. Samuel Mirsky, DVA Hospital, Ottawa; Mrs. Doris Small, district director, Greater Montreal Branch, Victorian Order of Nurses; Miss Enid Wyness, director, Social Service Department, Ottawa Civic Hospital; Dr. William Storrar, medical director, Montreal General Hospital; and Mrs. Margaret Pincock, executive director, Visiting Homemakers' Association of Ottawa. Miss Helen McArthur, national director, Nursing Services, Canadian Red Cross Society was moderator.

The participants opened the discussion by defining home care plans. Although opinions differed as to the origin or administrative body of the service, all were agreed that home care was the provision of services such as are found in a hospital for patients at home. In order to establish a plan the hospital must be thought of as a community agency.

The doctor makes home visits and, with the cooperation of both the hospital nurse and the visiting nurse, makes recommendations for other services for the patient e.g. homemaker.

The visiting nurse is seen as the member of the team who could supply information about the patient's home, family, culture, religion and community relationships. In her efforts to rehabilitate him she recognizes ways in which he may help himself and assists him to do so. She is the one who is closest to the patient and his family and as such can act as a counsellor to help the family and the patient to live with his disabilities. In order to fulfil her role she needs to be included in the pre-transfer conference before he leaves hospital since she will continue to act as a coordinator of services.

The social worker must have a good working knowledge of the role and competence of others on the team. Specifically, she is a case worker. She and the patient "look at the problem together," after which she can tap the sources of help in the community. "The coordinator of the team," the social worker stated, "may vary from time to time as the patient's needs change."

The homemaker should take part in home care planning — for the program as a whole and the individual plan for a specific patient.

Several recommendations evolved from the discussion which followed the symposium. In Canada we require the initiation of more pilot projects to determine the type of program we need. This could be done at the provincial level with support from federal health grants. The hospital bed situation is going to force us to do something. With present health insurance coverage, government or voluntary, the patient at home has to pay for his own services, e.g., nursing care, drugs. Hospitals for the chronically ill are not the answer, for the reasons outlined by Miss Magnussen. Do we need better utilization of existing personnel and services, coupled with involvement of the family? Dr. Mirsky stated that

it is not an exacerbation in chronic illness that causes readmission to hospital but deterioration of the home situation.

The primary need at the present seemed to be greater coordination of existing resources. Later in the conference, there was extensive discussion of our present situation and the implications for future planning.

On the morning of the second day, three discussion groups were formed according to interest areas — hospital, public health and nursing education. The group to which a participant was assigned was not necessarily their actual field of practice.

Reports of Groups

Hospital: Education must be broad. Existing personnel must be helped to see the need for home care and to understand the meaning of it. There must be motivation of all hospital personnel.

Doctors are a very important part of the planning. Their education could be undertaken by a doctor who was both knowledgeable and enthusiastic. At the Montreal General Hospital where a VON liaison is on the hospital staff it has been found that the number of referrals are in direct proportion to the VON's liaison with the doctors.

This group stated that we are not utilizing our visiting nurse services to the best advantage. We need a good referral system and an increased awareness and appreciation of visiting nurse services by all hospital personnel. If home care, as it is now, was better understood it could be made available to all, rather than only the indigent. Some means of achieving our goals would be:

> A reorganization of hospital care along the lines of progressive patient care; exchange of doctors and nurses from hospital to community; enlistment of support of citizen groups; drawing student nurses into districts and chapters of our associations, and constant education and interpretation keeping in mind that "illness is only an incident in the life of the patient."

Public Health: This group reiterated the need for pilot studies with emphasis on making all facilities available, not on who coordinates. These studies would show that home care plans will streamline visiting nursing service — they will not overload hospitals but help them. We need a broader based type of care from the community as a whole — this requires re-education. The advantages of home care as outlined by this group are:

> More patients may be cared for; pressure will be decreased as the average stay in hospitals will decrease; decrease in waiting time to enter hospital; improved quality of care; the patient will want to vacate the bed; the patient will have greater peace of mind regarding his family; home care can help to lead society back into the home.

The nurse is the key person, who must think of the role of other professions and her own role as a citizen.

Nursing Education: The goals and needs require a three-way program of interpretation — to doctors, to the public and to nurses themselves. This group asked themselves a question and then attempted to answer it. What kind of a concept are we giving our student nurses?

Basic nursing education could provide first level preparation in all fields. This is not specialization but the application of the same principles to different situations. In order to do this most effectively schools need to be educational institutions — financially and administratively independent of hospitals. The group emphasized the need for a new approach in nursing because patients are in the community as well as in hospital. A recommendation came for continuing and expanding leadership from universities. A body of nurses is ready to support reappraisal of basic and post-basic education.

It was hoped that by evaluation and accreditation on a national level through CNA leadership we would head toward greater standardization of nursing education in Canada. Home care plans could spearhead the drive for comprehensive nursing.

These group reports were prepared prior to Miss Magnussen's final presentation "The Impact of Home Care Plans on Nursing Education in Denmark." She started by stating that education for and in home care can be divided into five areas:

1. Basic nursing education
2. Special education for public health nurses
3. Preparation of the present visiting nurse for her job in home care (The visiting nurse in Denmark has not received post-basic public health education at a university.)
4. Preparation of leaders in home care
5. Education of other professions and the public in home care.

Basic nursing education: Why do we insist on speaking of the need for integration of social and health aspects in the basic curriculum — why not just comprehensive care? In Denmark in 1957 schools of nursing were approved and accredited. This was done by the National Health Service and a board on which the national nurses' association had representation. A curriculum was set up for all schools by this central body and is now under dual control — the central board and the board of the individual hospitals.

A curriculum guide was sent to each school which outlines the minimum requirements. There must be a visiting nurse and a government health officer on each school board. It is recommended that a public health nurse (one with post-basic education in public health) be a member of the teaching staff. A tradition in Denmark is that a young girl spends one year in a home other than her own, helping the mother with her children and learning to take care of a home. This year is a prerequisite to entrance into a school of nursing and has been found to help the student nurse to adjust better to the hospital and broader nursing situation.

The *public health nurse* needs special preparation in the preventive aspects of nursing.

Education of the visiting nurse is done on an inservice basis. It is an ongoing process. At the present time the responsibility is in the hands of the government health officer in each district.

We need to *prepare leaders* in home care in our own profession so that existing services may improve as they grow.

Other professions: In some areas medical students have been given practical training in public health and hospital nursing. This can be very effective. We need to explore how physiotherapists, occupational therapists, social workers, etc., can work together for the furtherance of home care. Education of the public requires nurses "to get out and sell." No progress can be made until the public is ready. Nurses are slow in helping the public toward this readiness.

Miss Magnussen emphasized that the program of home care in Denmark is still young. It is also too soon to evaluate the effects of legislation on the schools of nursing.

We in Canada, will follow with interest the expansion of these projects planned to meet more adequately the health needs of the Danish people.

PAMELA E. POOLE

Mental Health Institute

The School of Nursing of Dalhousie University, Halifax will hold a three-day institute on "Nursing Aspects in the Mental Health Program," February 24, 25 and 26, 1960. The sessions will be held in the auditorium of the nurses' residence, Victoria General Hospital, Halifax. The registration fee will be two dollars ($2.00).

The conference leaders are MISS P. C. PIKE, head of the Psychiatric Nursing Research Department, Allan Memorial Institute, Montreal and DR. ROBERT O. JONES, professor of psychiatry, Dalhousie University. Nurses wishing to attend this institute should contact **Miss E. A. Electa MacLennan, director, School of Nursing, Dalhousie University, Halifax** as soon as possible.

* * *

We wish to remind subscribers to the *International Nursing Review* that, beginning with the February, 1960 issue, the Review will be published six times a year instead of quarterly. Owing to the rise in printing and mailing costs, as well as to the cost of more frequent publication, the subscription will in future be 30 shillings sterling per annum or $4.50.

— *ICN Newsletter*

* * *

A new professional film entitled "Cerebral Vascular Diseases: The Challenge of Management," has been released by the American Hearth Association. The film demonstrates the latest methods for aiding recovery and rehabilitation of stroke patients through use of services and equipment available to all physicians.

A version of this film for lay audiences, entitled "Second Chance," can be of help in instructing families of stroke victims on rehabilitation procedures and as a visual aid in addressing non-professional groups.

Both are 16 mm. black-and-white sound films, whose production was aided by a grant from E. R. Squibb & Sons, division of Olin Mathieson Chemical Corporation. Prints are available for purchase or loan from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

Interpersonal Relationships: a Classroom Subject?

DOROTHY S. STARR, M.N.

Knowing how to get along well with others can lead to a more successful life for anyone. To be an effective nurse, this ability becomes a necessity. How can we help the nurse develop her understanding of people? Where do we start?

THE WAY in which a student nurse gets along with other people — with her patients and with other members of the nursing team — is a primary factor in the quality of her nursing care. The student's relationships with others, in her professional capacity, are therefore the concern of all those responsible for guiding her learning experiences. Is there something to be contributed in the classroom to the student's ability to form positive, helpful relationships? Specifically, can psychology and sociology, taught after the preclinical period, contribute to her capacity for significant interpersonal relationships?

Psychodynamic nursing is a new term for part of the old concept of nursing the patient as a whole. It seems to involve the nurse — student or graduate — in a more conscious interaction of her own personality with that of the patient. Is the nurse, by being "sweet and kind," meeting the dependency needs of the patient or is she, in fact, retarding his tentative reach toward independence in order to satisfy her own needs? Is she too maternal toward her patient or not maternal enough? She needs to observe the effect of her personality upon that of the patient and to be conscious of what his personality does to her, in turn.

Some of the techniques for exploring the realm of interpersonal relationships which are described and upon which research is reported[1], seem to require greater maturity and a wider knowledge of psychology than that developed by most students in a three-year basic nursing program with a secondary school education prerequisite. It is to be hoped that nurses will continue to learn following their graduation and will use their increasing experience to perfect varying techniques of psychodynamic nursing — interviewing, for instance. This seems to imply inservice training for graduate nurse staff as the need for it is felt. The student nurse of today whose education places greater emphasis on awareness of interpersonal relationships may feel a desire to continue these studies in an inservice educational program.

The aim and goal of nursing is health. In all bedside nursing care the nurse is striving, in cooperation with the patient[2], to return him to health — not just physical health but with unimpaired psychic faculties and, we hope, with better resources to keep himself from illness in the future. There are some critics of nursing education today who say that nurses are forgetting their primary role and are moving into areas more properly served by doctors, social workers and psychiatrists. It is true that, consciously or unconsciously, in a skilled or an awkward manner, the nurse is dealing with the patient's emotional problems day-by-day. "She can bring psychotherapeutic or psycho-noxious attitudes and behavior to a particular situation."[3]

Two sociologists, reporting an analysis of the nurse's role, say that

> the nurse, as a member of the health team, is a professional and is obligated to hold the welfare of the patient as of primary importance. As the expressive specialist on this team, it is her function to lower the tension level of patients and to keep the doctor-nurse-patient relationship harmonious.[4]

Student nurses, like many people

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outside of hospital circles, are interested and intrigued by the psychiatrically-oriented material, accurate or distorted, which floods the mass communication media. In addition to her curiosity and to the introspection which belongs to adolescence, we urge upon the student nurse consideration of the emotional needs of the patient. We ask her to look behind the patient's words for his meaning.

There is a *continuum:* recognizing emotional content, communicating that content, by word or attitude, to the patient; interpreting that content to the patient. The latter function is that of the psychotherapist. The second is that of the nurse with greater skill than we can help the student nurse develop under present conditions. This would leave as our present task helping the student to recognize the possible meaning of what the patient does and says. This would further mean, it seems to me, that the student needs to be aided in understanding first what she means by her own behavior and verbalization.

Hildegard Peplau[5] expresses the nurse's personal factor:

> A nurse cannot pay attention to cues in the situation when her own needs are uppermost and require attention in the situation. Her observations are, unwittingly, focussed upon the way in which her unrecognized needs are being met by a patient. A good deal of advice has been given to nurses on how to behave in relation to patients; it is a rare book that points out, in addition, the fact that the nurse may generate anxiety and guilt when her own needs operate outside awareness and are not met by patients. However, until the actual needs of the nurse are met or identified, so that she is aware of what they are and how they function as barriers to the patient's goals, she does not have control such as is required for carrying out all of the "shoulds" and "musts" indicated in nursing literature. She cannot gain rapport with patients when her own anxiety restricts awareness and limits her attention and observation to what brings approval for her.

Obviously we cannot hope to help every student to self-recognition but we shall have accomplished much if we can help a student to do the following:

1. Accept her failure to come up to her ideal of a nurse in the belief that she can grow and change. As long as she cannot accept her failure and so hides it from herself, she cannot change.
2. Accept the patient as different from herself without making value judgments about his standards and conduct or, at least, recognize that differences in standards and customs exist.

The focus of a short course of discussion on psychology and sociology should be on recognition of some of the general principles of human behavior, with observation of these principles in practice on the wards, under the supervision of clinical instructors as an added ingredient to all bedside nursing care. It is only through experience and experimentation that these concepts will become part of bedside nursing. So long as they remain abstract academic principles they will not enter into the nursing care of the patient.

A group of psychiatrists[6] who studied this problem stated,

> The instructor of nursing personnel has, in her relationship with her students, a royal opportunity to help them in their relationship with patients. The instructor, too, has to evaluate her own uses of defences against anxiety. One of the most common defences is the zeal with which various "ologies" are taught. Knowledge and memory are emphasized. Nursing routines are laboriously checked. Close relationships, living relationships, are avoided.
>
> We probably can teach didactically very little of value to the nurse in terms of dealing with patients. We can, however, provide situations in which she herself can learn with a minimum of anxiety. The nurse may gradually reach a high point of tolerance of anxiety because of her own self-knowledge. With experience she can learn not only to appreciate the dilemmas of her patients but also to help them through their disparate efforts to cope with them.

The course, as I envision it, would be conducted as a seminar with relatively small groups of students, not more than 20 in each, who might be seated in a semicircle or around a table. The principles are presented by the instructor although her seat in the circle or around the table does not have the formality of the starched, behind-the-lectern stance. In a 12-

hour course, the first two lectures would be devoted to a review of principles of psychology involving: the concepts of homeostasis; the hierarchy of needs; the physiological manifestations of emotion; frustration and conflict; and mechanisms of adjustment. The third period is concerned with some of the feelings that hospitalization and illness may arouse in the patient.

The subject of the meaning of illness to the patient is presented to students in many ways and at various times. It seems wise to present the emotional aspects of illness in a way less closely related to the medical aspects of the patient's illness. The classroom makes a more objective appraisal of the patient-nurse relationship possible. The atmosphere is conducive to considering principles and applying them to specific patient situations while separated from the urgency and stress of the work situation. Illness as an event will have been discussed in the classroom during the student's preclinical term, but in her third year she will have her own experience from which to draw illustrations.

In the fourth hour some of the feelings which the nurse may have in relation to the patient and to the work situation could be discussed. No attempt need be made to elicit personal experience illustrations although frequently a student may offer one. The subject should be approached in a manner calculated to arouse a minimum of defence. Many nurses have feelings of anxiety, rebellion against authority, conflict over opposing goals, anger, ambivalence over dependency needs, frustration over the gulf between the ideal and actual performance.

The fifth and sixth hours can be devoted to considering the kinds of personal relationships developed between student nurses and patients. Students may be asked to record conversations between themselves and their patients for later group discussion along the following lines: What did this patient really want from the nurse? and, what can the nurse do for this patient, considering his feelings and her own?

Since social and psychological factors cannot be distinctly separated, sociology follows psychology in an unbroken series. In sociology an attempt is made to select those principles which have direct application to the student's nursing experience and to re-emphasize constantly the relevance of the subject matter to the care of the patient in the hospital or in the community. Six hours are used to present the patient as an individual in society, as a member of the family, and as a member of the community, with approximately equal amounts of time spent on each topic.

The two hours devoted to the patient as an individual in society (by inference, the nurse or anyone else as an individual in society) cover the concept of culture with its subdivisions of folkways, mores, institutions and laws, and the way in which an individual learns about the society in which he lives, including concepts of role and status within the group.

The subject of the family is of great importance to the nurse. This topic provides perhaps the hardest task in selecting material to be included in a very short course. Mention is made of some of the forms of family structure, of the function of the family, and of the cultural changes in life on the North American continent and their effect upon family life. In the second hour, the family cycle is considered. The student is asked to discuss how a family changes when the first baby arrives, the pressure on family life when the children begin to leave home, and the readjustment in family life that aging brings.

Consideration of the patient's life in the community includes some discussion of housing; the ecology of cities; segregation, voluntary and involuntary; and the effect of housing on health problems. The last class period is centered on the groups in which the patient, or anyone else, lives and includes discussion of race, social class, ethnic and nationality groups. Again discussion is based on fact, as opposed to popularly-held misconceptions, and the effect that these divisions of mankind have upon health problems.

Another 12-hour course in ward administration primarily considers the relationship of the nurse to hospital personnel. In this course role-playing is used to help the student nurse

experience some of the situations in the protected environment of a small group in the classroom. Students role-play such situations as: the head nurse who must reprimand a student for failing to keep an intake-and-output record; the clinical instructor who investigates a student's indifference to the geriatric patient; the patient who complains to the student of her doctor's short visits and apparent lack of interest.

Discussions following role-portrayal center around: How would you have handled this situation? How would you have felt if you were in this position? Why don't you like to tell another member of the nursing team of an omission when it is your responsibility as team leader to see that all patients are given good nursing care?

The classroom teaching of interpersonal relationships in terms of psychology and sociology is aimed at introducing the student to new ideas and to a few basic concepts of these social sciences, in an atmosphere where she can learn and experiment with a minimum of anxiety. We feel that the classroom has a contribution to make to the student's capacity for significant interpersonal relationships.

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Nurse-Patient Relationships

CATHARINE BLACKLOCK

Success or failure! Good relationships can decide the effectiveness of your nursing care. Technical skill alone is only half the answer.

TECHNICALLY speaking, a relationship implies a state of being mutually or reciprocally interested. It is now apparent that nurse-patient relationships are as important as clinical skills in the basic principles of nursing care. There is a need for a well-defined philosophy of life as a basis for establishing more positive attitudes. The personality of the individual nurse is a very important factor in effective nurse-patient relationships.[1]

The nurse is now being educated to treat the patient not just as an appendectomy or a tonsillectomy, but as a living, feeling human being temporarily or permanently incapacitated by illness. To give this type of care, she must be prepared to help the patient psychologically and socially.

Psychological Preparation

"The same fire that melts the butter hardens the egg." Every personality develops continually from infancy until death, and throughout this span it persists even though it changes. Psychology is the study of behavior or misbehavior. It is the science that seeks to understand the activities of the individual. The individual is a

Miss Blacklock recently returned to Canada after several years as surgical supervisor at Mount Sinai Hospital, New York.

vital personality reacting to the environment created by his illness. Recognizing this interrelationship, it is obvious that the skillful nurse must minister to the patient's emotional needs as well as to the physical aspects of his pathological condition.[2]

The nurse has a more urgent need for psychology than most professional people. She needs to understand the basic principles of behavior not as abstract concepts, but as workable, practical aids which will assist her in recognizing how best to serve her patients and how to deal most tactfully with troublesome situations. She, more than anyone else, can stimulate the desire to live and to get well. She must have an interest in and a liking for the patient in order to enable him to return this feeling. She must have patience and understanding and be willing to listen. Each individual differs from all others and must be treated accordingly.

Sociological Preparation

The nurse should know and recognize her potential contribution in the various fields of social welfare. She should be prepared to:

give better nursing service to the patient; interpret the patient's problems to his relatives and friends; cooperate effectively with the physician in understanding the patient; learn more about the interrelation of health, social conditions and problems; contribute in greater degree to nationwide programs for health; carry out more intelligently federal or provincial welfare legislation such as the Workmen's Compensation laws.

The patient in thinking of his recovery, whether partial or complete, often must adjust to other and perhaps greater problems than his present condition. The nurse's first-hand study of social problems begins with the individual. She influences the total problem by the way in which she helps the patient. The patient's personality is an important factor in social adjustment.[3]

To treat this subject fully, it is necessary to consider the nurse-patient relationship in all types of hospitals and in the home.

In the General Hospital

In dealing with the patient in a general hospital, view him as having healthy potentialities and treat him accordingly. Ill patients have normal sensitivities. If anything, these sensitivities are more acute than normal. The nurse's function is to create situations that provide an opportunity for wholesome, balanced activity at the patient's level.[4]

In all nurse-patient relationships the nurse exerts inevitable influence. This influence is for good when she is a mature, generous, humble, understanding individual with a stable, wholesome personality structure that rises above irritations, resentment, pettiness and a narrow point of view. Successful relationships depend less on efficient administration of drugs and manipulation of equipment than on spirit, attitudes, values and sensitivities put into useful social practice. The nurse is not merely a dispenser of care. She is a vital part of it — a prime mover in all efficacious patient-nurse relationships.

Quite often the patient responds to stimuli so quickly and so vehemently that one can see the effect of care and especially the consequences of general attitudes and behavior. He teaches the nurse the importance of reciprocity in human relationships, and the need for honesty in social relationships.

Through contact with the patient one gains the experience that perfects study. Knowledge acquired in the classroom simply places the nurse in an intellectual relationship with the subject matter. It is while dealing with the patient that she has flashes of insight into his point of view. At the highest level, patient and nurse think and plan together, each aware of the particular contribution made by the other.

There are four levels of participation: coercive, permissive, directive, cooperative.[5]

1. The lowest level of participation is *coercive*. This is often necessary when force is needed as in the enforcement of communicable disease control or in the hospitalization of the psychotic patient. This is naturally not a satisfactory relationship for the patient or family.

2. A *permissive* relationship takes place when the patient is persuaded to accept treatment or to follow advice.

though he really does not want to do so. In this type of relationship the nurse decides and the family accepts but does not participate in the decision.

3. More satisfactory is the relationship in which the patient and nurse share in discussion and in planning. This may be called a participating relationship. It is really only *directive* but it allows the family to exercise some selection and choice in decisions.

4. When the patient or family and nurse are able to work jointly in the analysis and solution of problems and each contributes to the fullest extent throughout the entire process, the relationship may be described as *co-operative*.

Resistance to the efforts of the nurse may mean that while the patient needs help he is loath to get involved with ideas and plans that mean change. Change is a threat to established daily living which may not be comfortable itself, but is more comfortable than change. Change brings the necessity for thought and decision with subsequent feelings of discomfort unless happy results are quickly obvious.

A Formula

1. Actual interest in the patient's point of view and genuine respect for it — not assumed respect as a device for sugar-coating her "message."

2. Appropriate health information based on available research.

3. Skill in bedside nursing.

4. Belief on the part of the nurse that her professional purposes are of value.

This is a working formula which includes the emotional aspects and is designed to make the patient feel that identification with the nurse is worth while. It is not easy to go slowly, to stop for thought, to be aware of one's own reactions, to be willing to relate oneself to the lives of others rather than to direct them. The sum total is the straight road to a working relationship with the patient.

In the Special Hospital

In a large class of diseases mental symptoms take predominance over physical and are the first consideration in treatment and care. Before coming to the psychiatric ward, most nurses have the idea that all people who are mentally ill are irrational and do not understand what goes on around them. One of the fundamental ideas to grasp early is that the patient, regardless of his behavior, is a human being who thinks, loves and hates and has quiet and acute sensibilities. Pleasant reactions are very near the surface. They require only the right stimulus. Even with the unwholesome, disagreeable and sometimes offensive symptoms of mental illness, probably there are more sensitive, noble souls to be found in hospitals for the mentally ill than in any other one place. At heart the psychiatric patient is friendly and good. Unpleasant, perverse, unreasonable behavior is all part of his illness and corresponds to the fever, vomitus and vile breath of the patient on the medical and surgical ward.

Personality factors are stressed in nurse-patient relationships here because every word and act produces a positive or negative influence on the patient's immediate condition. Nurses, like other people, may be one of two fundamental personality types: those who focus primarily on people and those who focus primarily on things.

In dealing with the patient the nurse does not use little bits of energy now and then. It is necessary to think continually. Within her own mind, she establishes immediate and ultimate nursing objectives. She considers suggestions and associations that give meaning to the patient's behavior of the moment and plans a way to get the patient's state of feeling in line with the need. Getting the mood or the attitude of the patient in line with the need is something one learns by oneself for oneself.

Achievement in psychiatric nursing depends on the management of interpersonal relationships. This includes applying knowledge, spirit, interest, objectivity, tenderness in intellectual action. Through the behavior of the nursing personnel it is possible to make a patient feel calm, comfortable, secure and thereby change noise and uncontrolled activity to quiet and order. The nurse can see now more clearly and more specifically how better knowledge of human behavior fortifies her daily work, and how nursing can become part of the current mental hygiene program.

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In the Home

When the public health nurse offers her services to people who could profit from her knowledge but are not acutely ill or in obvious danger of illness, she finds herself entering upon a more complex situation than is presented in nursing the sick patient. Successful health teaching depends upon the relationship between the nurse and the individual. The latter must be made to feel that the nurse has some valuable information to offer him.

The use of the word "relationships" in a professional sense, while enlarging its meaning may obscure the original and still useful sense of the word for laymen or members of another profession. When you consider the relationships between two persons, as for example between the nurse and the person in the community with whom she forms a contact, one asks first whether the two "get on" together. Then you must consider how or on what basis they maintain their relationships. There is a need to study the attitudes of both, the interplay between them as revealed by their behavior, and finally the usefulness or fertility of the relationship in view of the objective in mind — here the teaching of health.[6]

When the patient accepts:

Many of the patients who welcome the help of the nurse are mature and well-adjusted. They are glad that a source of information on health matters is available. They recognize their own problems, and are even able to see their own mistakes. They may seek to make use of the nurse in many ways. These range from legitimate use of her superior health knowledge by people in need of advice in such matters, through an emotional dependency which may help or hinder according to the individual situation, to an attempt, often unconscious, on the part of the patient with marked personality problems to fit into the defense they have worked out for making life more endurable.

When the patient resists:

The nurse's ideals for her own conduct influence her methods of work with the patient. Unconscious emotional reactions on the part of the nurse may be a source of danger to the patient. The nurse should not try to judge the family by her own standards. Often she has a lack of understanding. The patient may be emotionally immature, or perhaps looks upon the nurse as a superior person unable to help her in her difficulties. If the emotional and intellectual needs and status of the patient are taken into consideration so that the information the nurse can offer is specific and appropriate, many of the other difficulties in making a "good" visit will be eliminated almost automatically.

Once a contact in the home has been established, the nurse must consider who is the "key person" in the family. Clarification of a difficult situation may follow a thoughtful selection of the member of the family with whom the nurse shall attempt to work out the strongest relationship. Sometimes it is a high school girl who frequently becomes more interested in family nutritional needs than a foreign-born mother. She can be depended upon to make use of her new ideas in the family since they are proud to accept this evidence of the child's progress. One pitfall that frequently endangers the nurse's relationships with the family is identification of herself with one member of the family who appears to warrant special sympathy and protection or with a certain faction in the family.

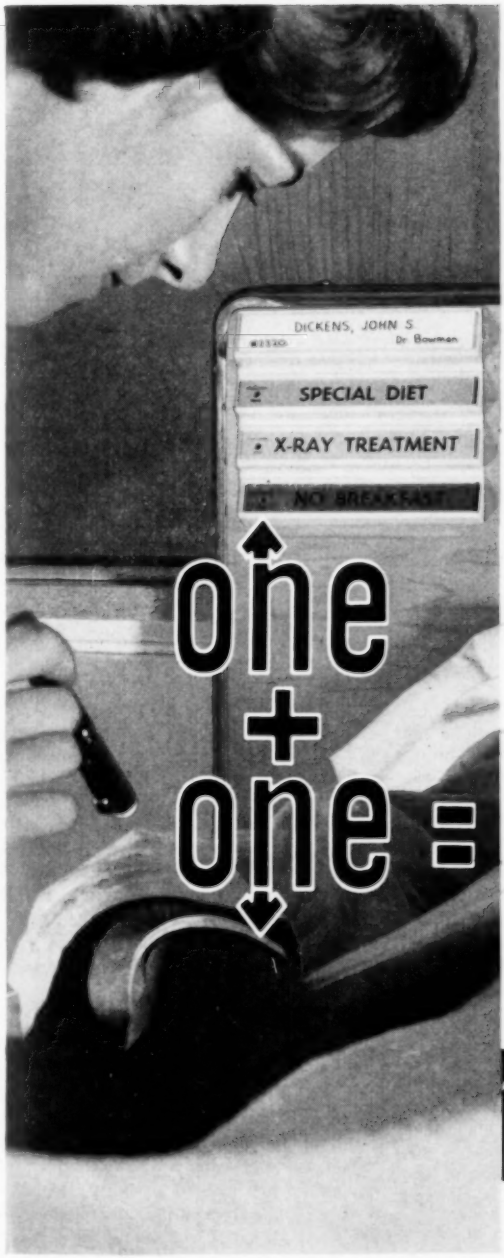
Obtaining insight

1. *Listening*: The opportunity to tell his fears and anxieties to a tolerant person who is not part of the situation yet understands what he is talking about, leaves the patient feeling that he has actually lost some of his troubles in the act of talking about them. This willingness on the part of the nurse to listen to him is a help to the patient and also aids the nurse.

2. *Questioning*: This is an activity which cannot be separated from learning. Unless the patient is under pressure to talk to the nurse because of his own interest or excitement, it may be the nurse's skilled questioning which will helpfully tap the reserves of the patient's feelings and will permit the nurse and the patient to understand each other more fully.

The nurse and the group

The nurse's customary gift for leadership helps her with the organization of such projects as a child



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health conference. She must ensure that speed, efficiency and the pressure of habitual routine do not blind her to ineffective results which may affect the children and the mothers who are attending the conference.

Any nurse who has conducted child health conferences has seen the therapeutic effect that this experience may hold for the child who is afraid or shy. Through observing him as one of this group she may learn to understand that the child's behavior is natural rather than "bad."

In conclusion it can be stated that: A good relationship is one that allows the nurse to accomplish in the most effective manner possible the task for which she has come to help the family or the individual.

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In the Good Old Days

(*The Canadian Nurse*, FEBRUARY, 1920)

The Necessity for Breast Feeding

A French medical journal, describing the work of the well-baby clinic at Lille during the German occupation, says that there was one unforeseen result. As the Germans carried off all the cows there was no milk; as the factories were not running, the women could not find wage-earning work, and were obliged to stay at home with their babies. The mothers were forced to nurse their infants to keep them alive and the infantile death rate was far lower than was ever known before in the town. He concludes that milk-distributing stations are a mistake, as they relieve mothers of their first duty.

* * *

The Industrial Nurse

It is stated that the first trained nurse to be employed as an industrial nurse was one engaged by the Vermont Marble Company, in 1895, to visit the homes of the employees and care for the sick mothers and babies.

* * *

Training School Requirements

The girl who enters a training school has a right to be given full and proper instruction. Likewise the public has a right to demand that, when a nurse assumes the responsibility of caring for the sick, she shall be fully qualified.

No hospital should be allowed to establish a training school unless it comes up to a required standard set by a governing body who are qualified to judge and determine what that standard shall be.

* * *

Registration in Britain

Congratulations from this magazine and from all the nurses of Canada to our sisters in England for the successful ending of their strenuous appeal to Parliament for registration, which has lasted for fourteen years . . . The law will enable nurses to organize their profession so that it may be a more efficient instrument for the service of the sick and suffering, and to raise the standard, through preventive work, of the national health.

Much outcry, little outcome. — AESOP

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JOHN GIBSON, M.B., Ch.B., D.P.M.

The drug addict — pitied or scorned? Addiction — sickness or crime, curable or incurable?

A DRUG addict is a person who takes excessive amounts of a drug or for prolonged periods without medical indications, develops a tolerance, and shows symptoms of withdrawal if he cannot get or is not given the drug. Most addicts show psychopathic traits before they become addicts. It is rare for mentally normal persons to become addicts, with the possible exception of some who are addicted to barbiturates. Any drug with sedative or hypnotic properties can become a drug of addiction. It is also commonplace knowledge that any drug used to relieve the symptoms produced by the withdrawal of another drug is itself likely to produce addiction. In some parts of the world, drugs are taken daily in small amounts by large numbers of people and produce mild addiction, for example opium in the Far East, cocaine in South America, and hashish (marihuana) in Africa and Asia. Of the drugs prescribed medically, the ones that commonly produce addiction are the barbiturates, opium and morphine, heroin, pethidine, cocaine, paraldehyde and amphetamine.

Barbiturates

Because of the large amounts prescribed for many nervous symptoms, addiction to barbiturates is probably now the commonest of all addictions in the western world. Patients thus treated can easily develop a dependence upon the drug and will show symptoms if it is withdrawn. That the patient has developed a tolerance for the drug can be deduced when he is able to take it by day and not become sleepy. Chronic intoxication with the drug may produce a state of hypomania resembling drunkenness, with an irritability and moodiness that the addict tries to relieve by taking more of it. Barbiturates are presently a common cause of accidental death and suicide. Withdrawal of the drug produces irritability, anxiety, tremor, sweating, palpitation and insomnia. The occurrence of any of these may, unfortunately, be taken as evidence of the continued existence of the mental state for which the barbiturate was originally prescribed. Treatment is by withdrawal of the drug and simple psychotherapy.

Opium and Morphine

In the Far East addiction is common since opium is commonly taken by mouth or by smoking. In other parts of the world the incidence of this particular addiction is highly variable. Its variability depends upon the number of psychopaths in the community and the strictness of the precautions taken by the state to control manufacture, prescription and sale. Addiction usually begins in early adult life and is often associated with addiction to other drugs.

Some addicts are happy on relatively small doses of drug, which they do not have to increase and on which they may be able to live happily and work efficiently as long as they are able to obtain it. Others take increasingly larger amounts with severe physical and mental effects. The addict develops a loss of appetite, constipation, malnutrition, anemia, abscesses at the sites of injections, and a poor resistance to infection. Mental changes include further development of psychopathic behavior, in particular unreliability, lying and stealing in order to obtain the drug. If the drug is withdrawn, withdrawal symptoms begin in about 24 hours and are at their worst in 72 hours, after which they abate. They include headache, nausea, vomiting, diarrhea, anxiety, restlessness and insomnia. The symptoms are so distressing that few addicts are willing to endure them.

Treatment is by rapid withdrawal of

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the sixth of a series of articles on psychiatric subjects.

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the drug over the course of three or four days. More gradual reduction is useless. Sedation is accomplished by the use of barbiturates, paraldehyde or methadone. The latter is itself likely to produce an addiction, although a milder one. Modified insulin treatment and subsequent psychotherapy are also used. So unreliable are the patients that treatment can be carried out only in a hospital or in the home where full supervision can ensure that the addict has no access to the drug. Many addicts abandon treatment and relapse is all too common.

Heroin

Diamorphine hydrochloride produces addiction easily. It may be preferred by some addicts because of the intensity of the euphoria and the freedom from vomiting and diarrhea. Severe physical and mental deterioration is produced, and the addiction is very difficult to cure.

Pethidine

This is a synthetic drug that is used as a substitute for morphine in the relief of pain, spasm and cough. Addiction to it is more severe than that produced by morphine. It is more rapidly acquired and very difficult to cure. Tolerance and dependence develop quickly but some addicts have killed themselves with overdoses. With large doses tremors, twitchings, convulsions, confusion and hallucinations may occur. Addicts often take other drugs as well. Treatment is as for morphine addiction and is usually as unsuccessful.

Cocaine

This drug is taken by subcutaneous injection or as snuff which may cause perforation of the nasal septum. Addicts are usually grossly psychopathic, often existing as female or male prostitutes, alcoholics, or multiple-drug takers. Cocaine produces elation, overactivity, freedom from fatigue, facile thoughts, glibness and restlessness. When the effects begin to wear off, apathy and depression drive the addict to take more. Short-term psychoses may be produced in which the addict is confused, deluded, hallucinated and paranoidal. Treatment by withdrawal or any other method is rarely successful because few cocaine addicts are willing to leave the sort of society in which the cocaine habit is practised.

Marihuana

Hashish or Indian hemp produces a euphoria that once experienced is usually much desired. It tends to produce excitement, irresponsible behavior, a delirious state and violence. "Reefer" cigarettes containing it are said to be smoked by dance-band players to produce an extra frenzy in their playing.

Paraldehyde

This preparation is occasionally taken in excessive amounts by alcoholics in spite of its persistent and unpleasant smell. It is important that alcoholics should not be prescribed paraldehyde, except during the acute phase of delirium tremens when it is the safest hypnotic to give.

Amphetamine and Dexamphetamine

These preparations are taken to overcome fatigue and depression, to promote efficiency and alertness, and to acquire confidence. They may become drugs of addiction. Some people develop a great tolerance for them. They may produce irritability, restlessness, overactivity, insomnia, exhaustion, aplastic anemia, and short psychotic reactions with delusions and hallucinations as prominent symptoms. Withdrawal produces anxiety, restlessness and insomnia.

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THE GOOD THEY DO NOW—LASTS A LIFETIME

A Step Forward at Thistletown

SUE MOORE

The emotionally disturbed child! A sorry thought, to be sure, but this author is no longer sad; she paid a visit to Thistletown.

JUST inside the boundary of Metropolitan Toronto a winding road leads to the entrance of a large, pleasant building surrounded by 98 acres of partly wooded, slightly hilly countryside. There, in the summer months normal-looking children can be seen playing. Behind these normal appearances, however, there are many strange and serious anxieties, for these are emotionally disturbed children.

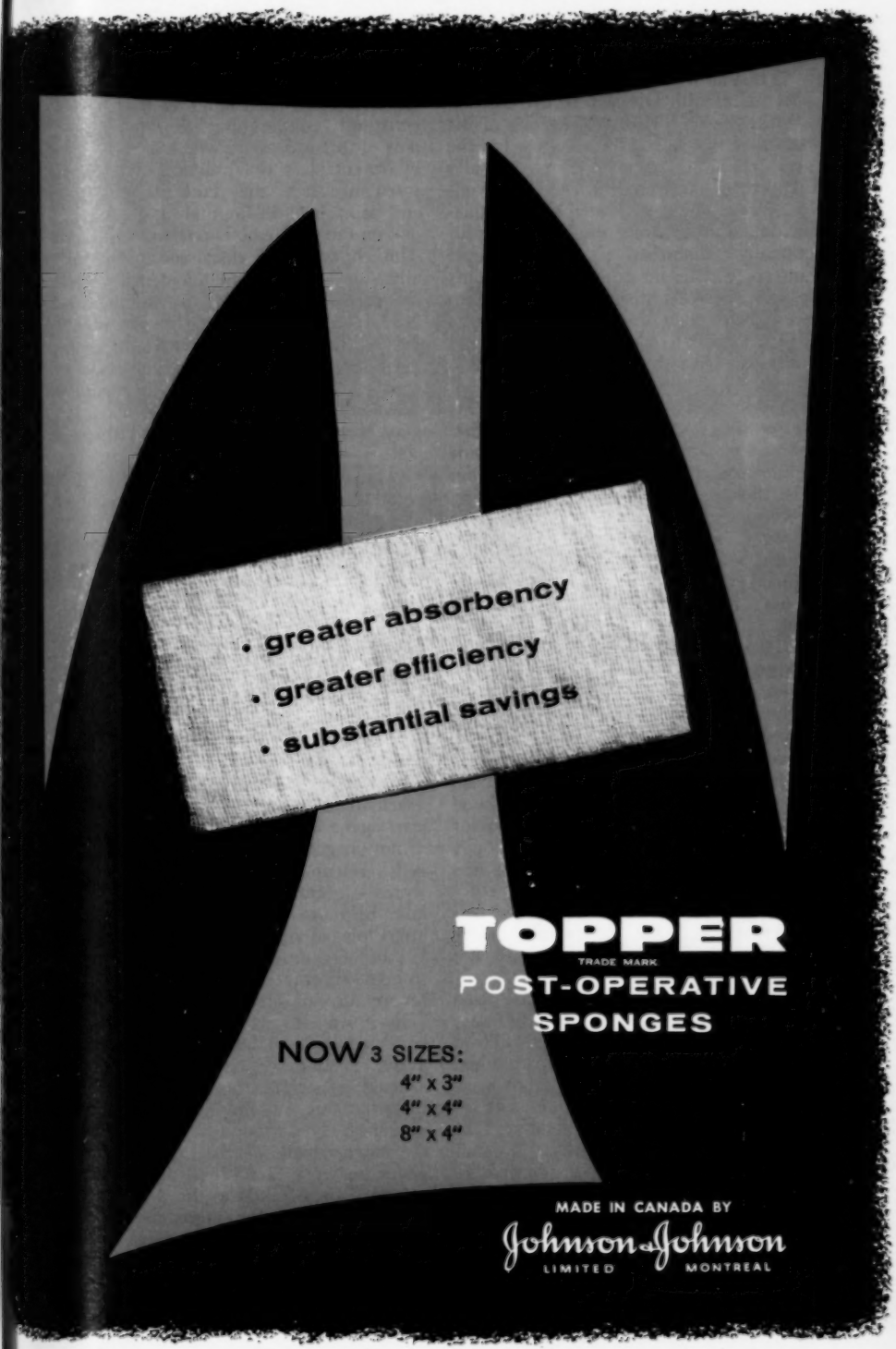
The building is Thistletown Hospital, constructed in 1929 as the country branch of the Hospital for Sick Children, Toronto. On February 8, 1957 the Ontario government announced the purchase of Thistletown, to be used as Canada's first psychiatric treatment centre for children. This purchase was the result of a survey made by Dr. W. R. Keeler, which revealed the serious lack of residence facilities in Canada for the treatment of emotionally disturbed children. Throughout Ontario there are several outpatient services and small residential centres such as, the Sunnyside Children's Centre in Kingston and the Protestant Children's Village in Ottawa, but these are essentially for less severely disturbed children. Facilities were needed which would provide the more extreme cases with constant observation and treatment in a protected and understanding environment. Thistletown was the answer though at the time of purchase it was still only an idea and a hope.

In January, 1959 I saw it as a reality, and was considerably impressed by the progress that had been made since it was opened the year before. The interior of the building had been redecorated. A gymnasium and a swimming pool were being added.

The building is now made up of three wings. The first contains offices for doctors, social workers, an occupational therapist and the dentist. The other two wings divide naturally into four living areas. On the lower floor are two wards for boys and girls under twelve years. These contain several large rooms, with varying numbers of beds. At the end of each ward there is a spacious, cheerful playroom where the children spend a great deal of time with their counsellors. There are two similar wards on the upper floor that are not in use yet but will eventually house adolescents. When the hospital is in full operation it will accommodate 72 children; during my visit there were only 18. In the basement there are more rooms for recreation including two small gyms, a workshop and a ceramics room. Here, qualified staff members teach the children to use their hands and to express themselves through building and modelling. At the end of the hall there is a rather formidable looking room with barred windows and mats on the floor. This room is used when a child gets out control. Instead of leaving him to overcome his anxiety alone a doctor or counsellor either goes into the room with him or waits outside until he has calmed down enough to talk. In this way treatment is administered as soon after the disturbance as possible instead of waiting for four or five hours when the child will not really care about it.

I was also shown the cafeteria where a counsellor was eating at each table with two or three children. Next to it was an interesting playroom. Along one side was a wide strip of mirror; opposite was a similar sheet of glass resembling a window. The children could not see through it but in the little room next door the doctors could watch and hear their patients at play. This enabled them to discover factors about the children

Miss Moore was a student in Queen's University School of Nursing, Kingston, when this visit was made.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which might not be evident if the doctor was present.

Thistletown is administered by the Mental Health Division of the Ontario Department of Health. The aim of the hospital is to provide a centre for the residential treatment of emotionally disturbed children from six to seventeen years of age. There is often misunderstanding of the expression "emotionally disturbed"; many people interpret it as meaning retarded. This is not correct. Most of the children at Thistletown have relatively high IQ's, although some may be retarded as a result of their emotional disturbance.

Admission to the hospital depends upon the severity of the child's disturbance, and the presence of some indication that he will benefit from the hospital's program. After being recommended by a psychiatrist the child is interviewed at an outpatient clinic, and accepted only after careful consideration by the doctors at Thistletown. There is a very long waiting list.

There is a great variety of emotional illness treated at Thistletown. Some of these disturbances are: neuroses, primary behavior disorders, certain types of delinquency, brain damage and epilepsy combined with emotional disorders, and psychotic illnesses of all types including autism or childhood schizophrenia. Many of these behavior problems have been accentuated by a lack of love or an unhappy home life. The disturbances cause various reactions; some of the children are agressive and even violent whereas others withdraw from society and may not move or speak for several hours.

Several types of treatment are used to try to gain understanding of these anxieties, and to prepare the children to return to their homes. In individual psychotherapy the doctor talks with the child, in the hope that he will reveal something of his difficulty. This approach is more effective at Thistletown than at an outpatient centre because the child is able to discuss any emotional upset at the time or soon after it has happened and is more likely to be aware of his trouble.

Particular emphasis is being placed on *milieu therapy*. In this the treatment depends upon all the child's surroundings and the people who come in contact with him. Everyone on the staff is trained to understand and take an interest in each child so that he is constantly undergoing therapy. One part of this procedure which is especially beneficial is the practice of having ward meetings; they take place at the end of each eight-hour shift, and anyone on the staff who is free may attend. The children are discussed individually, and any recent incidents with, or unusual observations of a child are brought up. Since these children react very differently to different situations these sessions result in a better understanding of the child, by everyone.

Another type of treatment used is *play therapy*. The occupational therapist is especially interested in it. In the large sunny playroom she can do wonders with the children by means of various games. She told about one little boy named Jimmy who, at times, would be extremely aggressive and at other times would withdraw completely into a world of his own. Her job was to help him face reality so that he would eventually arrive at the level where he could talk to the doctors and associate with others. She began by spending a certain length of time each day with him. At first he threw blocks at her, so she put these away and began making paper puppets, such as a witch to represent a naughty child and an angel, a good one. After a while Jimmy began making the puppets himself, unconsciously expressing his world of fantasy. By this means and later by more complex games, he took steps toward a return to reality.

Another thing which I found very interesting was the treatment and interpretation of *misbehavior*. During my visit it was discovered that five boys had broken a window and had run away. I was surprised that no one seemed especially alarmed, but was told that this was quite a common occurrence. The grounds are large and the town small so that the children never get very far. When the children returned they talked to the doctor and each was given the punishment that would do him the most good. This action, which seemed punishable to me, was actually a step in the direction of recovery. The children had cooperated in a group, whereas previously

WHY KNOX SPECIAL DIET BROCHURES ARE BASED ON FOOD EXCHANGE LISTS

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You may eat these foods any time of the day you wish . . . however, it's advisable to divide them into 3 equal meals.

MEASURE CAREFULLY . . . USE STANDARD MEASURING CUPS AND SPOONS

VEGETABLE LIST

Each of the following food choices contains little carbohydrate, protein or calories.

1200 CALORIE DIET · Choice of any number

1600 CALORIE DIET · Choice of any number

1800 CALORIE DIET · Choice of any number

In Raw Form, Size of Serving Unlimited; Cooked, Size Serving ½ to 1 cup.

Asparagus	Eggplant	Dandelion
Broccoli	Lettuce	Kale
Brussels sprouts	Mushrooms	Mustard
	Okra	Spinach
Cabbage	Pepper	Turnip greens
Cauliflower	Radishes	Sauerkraut
Celery	Greens:	String beans
Chicory	Beet greens	Summer squash
Cucumber	Chard	Tomatoes
Escarole	Collards	Watercress

OR You may choose from this vegetable list. Each of the following foods contains 7 grams carbohydrate, 2 grams protein, 35 calories.

1200 CALORIE DIET · Choice of any 2

1600 CALORIE DIET · Choice of any 4

1800 CALORIE DIET · Choice of any 4

One Serving Equals ½ cup.

Beets	Peas, green	Squash, winter
Carrots	Pumpkin	Turnips
Onions	Rutabagas	

BREAD LIST

Each of the following food choices contains 15 grams carbohydrate, 2 grams protein, 70 calories.

1200 CALORIE DIET · Choice of any 3

1600 CALORIE DIET · Choice of any 4

1800 CALORIE DIET · Choice of any 3

	Amount to Use
Bread	1 slice
Biscuit, roll (2" diameter)	1
Muffin (2" diameter)	1
Cornbread (1½" cube)	1
Cereals, cooked	½ cup
Dry, flake and puff types	½ cup
Rice, grits, cooked	½ cup
Spaghetti, noodles, cooked	½ cup
Macaroni, cooked	½ cup
Crackers, graham (2½" sq.)	2
Oysterettes (½ cup)	20
Saltines (2" sq.)	5
Soda (2½" sq.)	3
Round, thin	6
Flour	2½ tablespoons
Vegetables	
Beans and peas, dried, cooked (lima, navy, split peas, cowpea, etc.)	½ cup
Baked beans, no pork	¼ cup
Corn	½ cup
Popcorn	1 cup
Parsnips	⅔ cup
Potatoes, white	1 small
Potatoes, white, mashed	½ cup
Potatoes, sweet or yams	¼ cup
Sponge cake, plain (1½" cube)	1
Ice cream (omit two fat choices)	½ cup

MILK LIST

Each of the following food choices contains 12 grams carbohydrate, 8 grams protein, [illegible] and 170 calories.

1200 CALORIE DIET · Choice of any 1

1600 CALORIE DIET · Choice of any 2

1800 CALORIE DIET · Choice of any 2

	Amount to Use
Whole milk (plain or homogenized)	1 cup
*Skim milk	1 cup
Evaporated milk	½ cup
Powdered whole milk	¼ cup
*Non-fat dry milk solids	¼ cup
Buttermilk (made from whole milk)	1 cup
*Buttermilk (made from skim milk)	1 cup

You can use the milk on your meal plan in coffee, on cereal, or with other foods.

*Skim milk products contain less fat. When using skim milk, add 2 fat choices to get the same [illegible] as in whole milk.

FAT LIST

Each of the following food choices contains 5 grams fat, 45 calories.

1200 CALORIE DIET · Choice of any 1

1600 CALORIE DIET · Choice of any 2

1800 CALORIE DIET · Choice of any 2

	Amount to Use
Butter or margarine (1 small pat)	1 teaspoon
Bacon, crisp	1 slice
Cream, light	2 tablespoons
Cream, heavy	1 tablespoon

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cheese	1 tablespoon
(4" diameter)	½
dressing	1 tablespoon
naise	1 teaspoon
cooking fat	1 teaspoon
	6 small
	5 small

T LIST

f the following food choices contains 10 carbohydrate and 40 calories.

CALORIE DIET · Choice of any 5

0 CALORIE DIET · Choice of any 5

0 CALORIE DIET · Choice of any 5

	Amount to Use
(2" diameter)	1 small
	½ cup
a, fresh	2 medium
a, dried	4 halves
	½ small
berries	1 cup
berries	1 cup
berries	1 cup
berries	⅔ cup
loupe (6" diameter)	½
	10 large
	2
	2 large
ed	1 small
uit	½ small
fruit juice	½ cup
	12
juice	¼ cup
elon, melon, medium	½
	½ small
	1 small
juice	½ cup

Papaya	⅓ medium
Peach	1 medium
Pear	1 small
Pineapple	½ cup
Pineapple juice	½ cup
Plums	2 medium
Prunes, dried	2 medium
Raisins	2 tablespoons
Tangerine	1 large
Watermelon	1 cup

You may use your fruit fresh, dried, cooked, canned or frozen as long as no sugar has been added.

MEAT LIST

Each of the following food choices contains 7 grams protein, 5 grams fat, 75 calories.

1200 CALORIE DIET · Choice of any 4

1600 CALORIE DIET · Choice of any 6

1800 CALORIE DIET · Choice of any 6

	Amount to Use
Meat and Poultry *(medium fat)* 3-4 Oz. Average Serving (Beef, lamb, pork, liver, chicken, etc.)	1 ounce*
Cold cuts (4½" x ⅛") Salami, Minced Ham, Bologna, Liverwurst, Luncheon Loaf	1 slice
Frankfurter (8-9 per lb.)	1
Egg	1
Fish: haddock, flounder, bass, 3-4 Oz. Average Serving	1 ounce*
Serving Salmon, tuna, crab, lobster	¼ cup
Shrimp, clams, oysters, etc.	5 small
Sardines	3 medium
Cheese, Cheddar type	1 ounce
Cottage	¼ cup
Peanut butter	2 tablespoons

**Equals 1 Meat Choice; 3 oz. serving uses 3 Meat List Choices.*

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OR

As a hot drink (with Bouillon). Sprinkle 1 envelope Knox Gelatine on ¼ cup cold water to soften. Add 1 bouillon cube and ¾ cup boiling water. Stir until gelatine and bouillon cube are thoroughly dissolved. ¼ cup of any very hot broth may be used in place of bouillon.

After you have reached your weight goal . . . take Knox "Booster" Drink (with milk) to maintain weight and to supply additional protein. 1 (8 oz.) glass contains 15 grams protein, 130 calories. In an 8 or 10 oz. dry glass, thoroughly mix 1 envelope Knox Gelatine with 3 to 6 tablespoons *instant* non-fat dry milk (varies with brand). Fill with cold water. Stir briskly until milk thoroughly dissolves. Drink quickly.

OOD EXCHANGES

1. are authoritative[1]
2. eliminate calorie counting
3. provide a wide variety of food
4. assure a balanced intake protein*, carbohydrate, and fat

1. The Food Exchanges Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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each had kept to himself. Almost everything that happens at the hospital is converted into a contribution towards the children's recovery.

School is held at Thistletown in a classroom similar to a regular one. There is only one teacher at the hospital now, but eventually they hope to have a principal and five teachers.

The rest of the staff consists of several psychiatrists, a psychologist, group and case social workers, a part-time dentist, an occupational therapist and approximately one counsellor or child care worker for each child. These counsellors work on eight-hour shifts since no one on the staff lives right in the hospital. It is felt that a change of environment is a necessity for the staff.

The training program for the counsellors or child care workers is one of the main projects of Thistletown and is an important part of the new plan. They come from varied background and experiences; some have only high school graduation whereas others have university degrees or training in a special field. A one or two year course is offered depending on the qualifications of the applicant. There are regular lectures on such subjects as child psychology, psychiatric theory and group dynamics accompanied by a great deal of practical work. Numerous graduate nurses have taken the course. There are also two nurses who care for the physical health of the patients.

It is intended that the treatment program will be intensive and short, lasting about six to twelve months. However, the time limit is flexible enough to vary with the needs of the individual. When the child has improved enough he returns home if his family conditions are satisfactory. If he is a ward of the Children's Aid he is placed in a suitable foster home. If, after the normal time limit, a patient shows no sign of benefiting from the program he will be sent to another hospital for further treatment.

Thistletown is also being used for research. Long and short term programs are being developed. Data gathered will be available to research workers at the university. In both the research and counsellor training programs Thistletown is paving the way for more hospitals of this kind.

What impressed me most about Thistletown was the new approach which is being taken to this type of mental illness. I found the many original methods and attitudes most interesting and was amazed at their effectiveness. In Britain and the United States there are centres that have been using these methods for several years, but Canada has been far behind. Thistletown, therefore, marks a step forward in the treatment of emotionally ill children.

Greetings from the ICN President

New Year's Greetings to each of you!! It is a joy and a privilege to send a message of good will to our ICN members in all parts of the world.

The past year has been a busy one. We are proud of the progress achieved but concerned about the magnitude of the task before us. We are encouraged by the increased opportunity to be of service but at times frustrated by the limitations of our resources to give that service. However, pride, concern, encouragement, and even frustration can become the stepping-stones to our future success.

As nurses and as citizens the demands and responsibilities for the next year will, undoubtedly, be even more complex. Let us dedicate ourselves anew to the furtherance of our mutual goals — having the courage to extend our programs, the willingness to give ourselves still further, and the faith that we WILL succeed.

Thank you for your loyal support of the ICN during 1959. The ICN will continue to grow in usefulness as we have the benefit of your wisdom, loyalty, and friendship in the years to come. May 1960 bring you a rich measure of personal happiness and professional satisfaction.

— Agnes Ohlson

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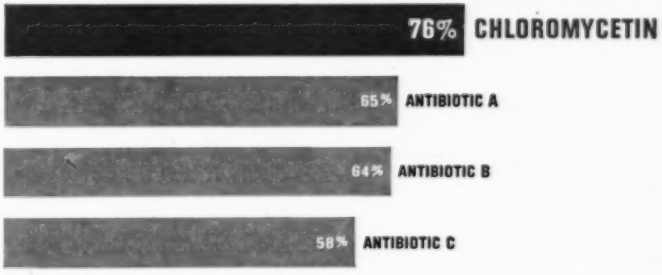

*Adapted from Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibáñez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414.

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In Memoriam

Mrs. Hughena Jean Black who graduated from St. Joseph's Hospital, London, Ont. in 1953, died on February 7, 1959.

* * *

Agnes (Beahan) Cumming, a graduate of St. Luke's General Hospital, Ottawa, died recently.

* * *

Mayme E. (Pritchard) Dinning, a graduate of St. Luke's General Hospital, Ottawa, died recently.

* * *

Margaret Drew, a Nova Scotia nurse who graduated from a Boston, Massachusetts hospital in 1908, died on August 11, 1959. During World War I she served overseas.

* * *

Yvonne Thérèse (Cottreau) d'Entremont who graduated from the Children's Hospital, Halifax in 1956, died recently in a motor accident. She was on the staff of the Faulkner Hospital, Jamaica Plains, New York.

* * *

Jane Grant, a graduate of a Minneapolis hospital in 1899, died on October 4, 1959. For a number of years she was in charge of the social service department of the Toronto General Hospital. Later she worked with the Visiting Nurses' Association in Cleveland, Ohio.

* * *

Blanche Marier, a graduate of Hôpital du Sacré Coeur, Cartierville, P.Q., in 1943, died on September 26, 1959. She had engaged in institutional nursing.

* * *

Mary McKeil who graduated from Victoria General Hospital, Halifax in 1903, died on October 22, 1959. She was charter and honorary member of the RNANS and a charter member of her hospital's alumnae association. Miss McKeil was 82.

* * *

Eleanor McPhedran, a Canadian graduate of the New York Training School of Nursing in 1906, died on October 25, 1959. A former assistant matron of Calgary General Hospital and matron of Ogden Convalescent Hospital, Miss McPhedran served in Canadian general hospitals in England and France during World War I. Following her return to Canada, she was appointed as matron of the Colonel Belcher Hospital, Calgary. Later she became matron of the Central Alberta Sanatorium from which she retired in 1935 to become secretary of the Calgary branch of the V.O.N. She was extremely active in the organization of the nurses of Alberta and became the first nurse to register with the AARN following its incorporation in 1916. She was appointed as the first nurse registrar of the association. In recognition of her contribution to nursing in Canada, Miss McPhedran was awarded the Mary Agnes Snively Medal.

* * *

Mary Margaret (Curtis) Ruddy who graduated from the General Hospital, Oshawa, Ont., in 1941, died during 1959. She had engaged in institutional nursing prior to her marriage.

* * *

Blanche M. Shute, an Alberta nurse and faithful supporter of the AARN, died recently.

* * *

Mary Sim, a graduate of Owen Sound General and Marine Hospital in 1905, died on November 19, 1959. She had engaged in private nursing for many years until advanced age and ill health forced her retirement. She was 85 years of age.

* * *

Sister St. Francis Xavier of the Sisters of St. Francis of Assissi, Hôpital St. François d'Assise, Quebec, died on November 21, 1959. Sister had served as instructor and director of nursing education at Ste. Jeanne d'Arc Hospital, Montreal, and Hôpital St. François d'Assise, Quebec.

* * *

Gladys Lillian (Crozier) Stewart who graduated from Brockville General Hospital, Ont., in 1928, died recently. She had engaged in private nursing.

* * *

Dorothy Eileen (Heinmiller) Swenerton, a graduate of Toronto General Hospital in 1943, died on October 29, 1959, in Kamloops, British Columbia.

* * *

Frances L. (Richards) Watson who graduated from the Hospital for Sick Children, Toronto in 1956, died during 1959. She had engaged in institutional nursing.

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— George Herbert

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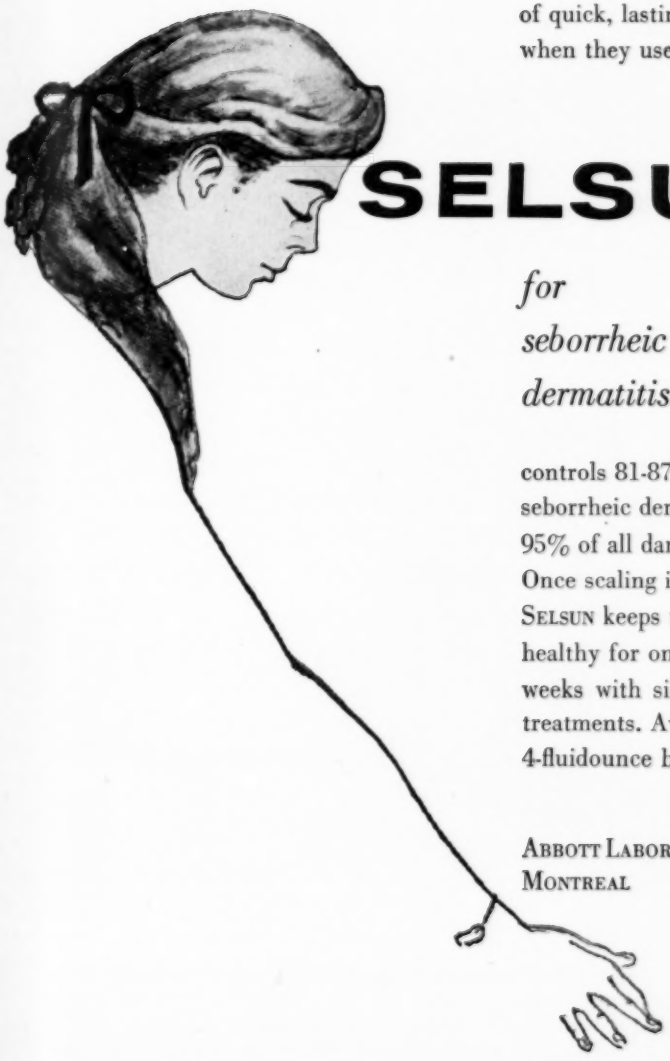

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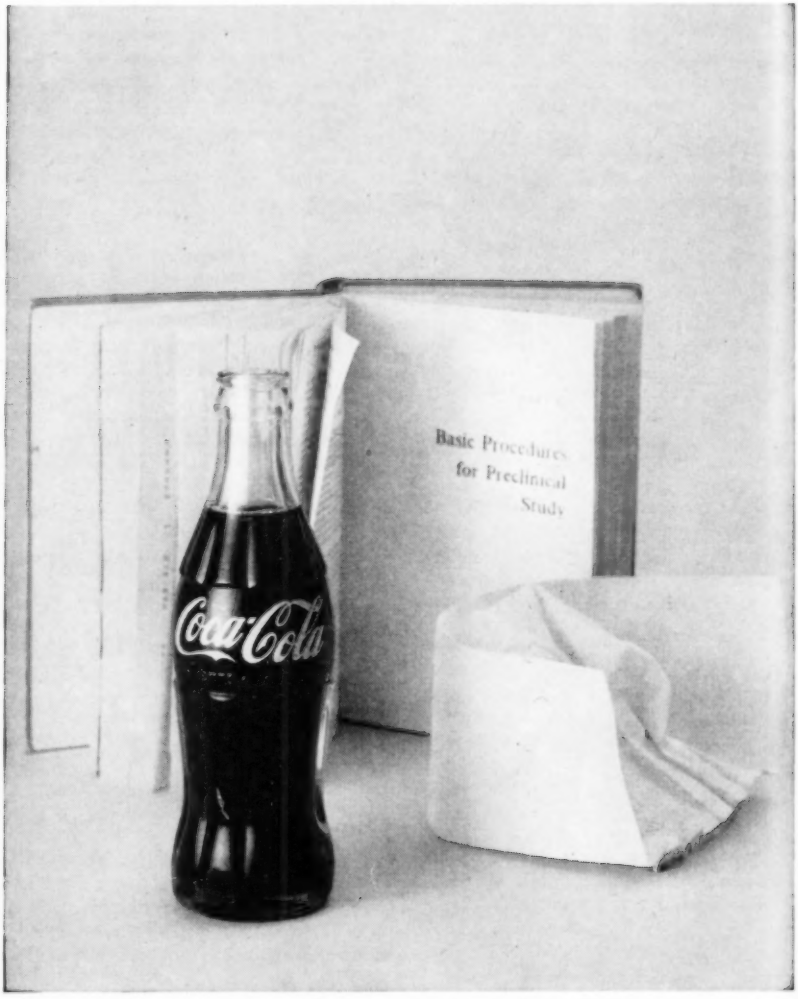

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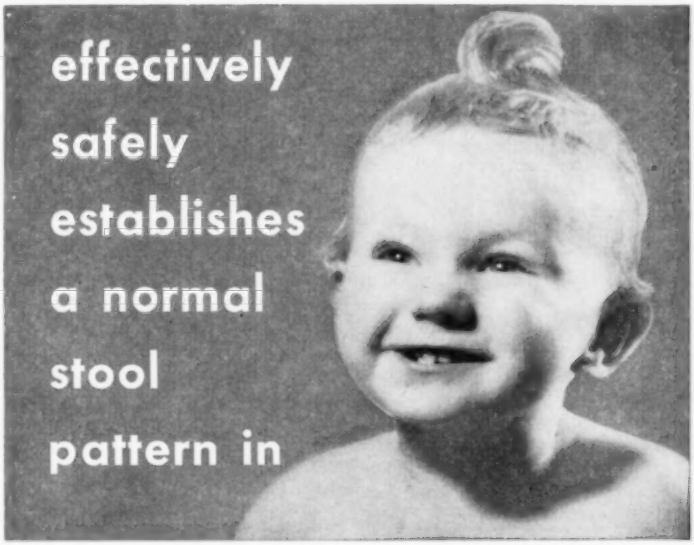

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Book Reviews

History and Trends of Professional Nursing by Deborah MacLurg Jensen, R.N., B.S., M.A. 610 pages. The C. V. Mosby Company, St. Louis, Mo. 4th ed. 1959. Price $5.25.

Reviewed by Miss Isabel Misener, Director, School of Nursing, Victoria General Hospital, Winnipeg.

In this edition, the author has aimed at a review of historical events and at stressing the widening role of the present professional nurse in society. This has been done in a fine manner. One cannot read the book without feeling that nursing is being placed more and more among the leading "social" professions and that it is being solidly combined with education.

It is important for the nurse to know what the past has been, in order that she can understand the relationships and changes of today. For centuries, nursing and hospitals were outgrowths of charity. It was not until the social outlook changed that a broader view toward the health of the public was taken. The reformation, the industrial revolution, the machine age, the enfranchisement of women, all had an effect on nursing. One of the most important results was the entire reform of nursing education. This book deals primarily with that topic. The dominant figure in the development of professional nursing was Florence Nightingale. She realized that knowledge and skill were necessary and that these could be achieved only by education. At the time of her death, the nurse had professional status, and there was an urgent need for organized schools of nursing.

The period from 1870 portrays interestingly the early schools of nursing, their weaknesses and their aims, the improvement of educational standards, and organization within the profession. The author has pointed out such major changes as the growing awareness of the need for research; the role played by the nurse in community health, and the gradual recognition by governments that nursing education is one of their responsibilities.

The questions and study projects for the individual units are to the point. The section on legal aspects is concise and well-expressed. The graduate nurse is given ample help and suggestion for her planning for the future. The book is a major contribution, and a challenge to us to help in the continual advancement of nursing education.

Microbiology by Louis P. Gebhardt, Ph.D., M.D. and Dean A. Anderson, M.S., Ph.D. 476 pages. The C. V. Mosby Company, St. Louis, Mo. 2nd ed. 1959. Price $5.75.

Reviewed by Sr. Capt. Ethel Kollin, Director of Education, Grace Hospital, Winnipeg.

This book is written to provide a broad general course for university and college students. It could be used with profit by students interested in microbiology as related to public health, sanitation, industry, food preparation and food handling.

The author has produced a very readable book that includes new and up-to-date material. The many applications to everyday living help to stress the practical as well as the scientific point of view.

This book would make good reference reading for a nurses' library, particularly the sections on sanitation, industry, antibiotics and pathogens. The latter is clear, concise and provides descriptions of organisms involved, the mode of disease production and the methods used to detect the causative agent. As a text for nurses I feel that:

1. The application of basic principles to nursing situations is lacking or very brief: for example, provision for and maintenance of aseptic technique in nursing measures to prevent cross infections.

2. Technical material and specific tests occupy space out of proportion to a nurse's need.

3. The sections on public health organization and problems is well written but apply specifically to the United States. There is a very brief history of international organization but no reference to Canada or other countries.

Human Relations in Nursing by Wayland J. Hayes, Ph.D. and Rena Gazaway, R.N., B.S., M.A. 486 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 2nd ed. 1959. $5.25.

Reviewed by Mrs. Hester Kerneu, associate professor in public health nursing, University of Saskatchewan, Saskatoon, Sask.

The objective of this book is "to help

nurses gain maximum insight concerning the human relationships involved in professional service." A high degree of skill in human relations is emphasized today as a desirable attribute of the professional person whatever his field of technical competence. This is especially true in nursing which traditionally has held sympathetic personal attention to the patient as a central feature of the professional role. At times the pressure for efficiency in the performance of technical functions has resulted in an impression of lack of warmth in nurse-patient relationships and neglect of what is now referred to as "the patient as a person."

It is believed that one way to correct this lack and to provide a balanced approach to the health and social problems of patients and families is through greater emphasis in nursing education on the use of concepts from the social sciences. This textbook is designed for such use and could be considered as comparable to anatomy and physiology texts which, in the area of biological sciences, provide basic concepts to be applied in nursing practice.

Part One provides an orientation to sociology with illustrations of basic concepts drawn from nursing as well as from previous common experience. Chapter seven — "Society Implies People" — is typical of the style. Demography is presented as a body of knowledge essential to the understanding of problems of health and medical care, and to planning changes in nursing education and nursing service to meet the need of society. A minimum of statistics, based on United States data, is used and is presented in clear, comprehensible tables that clarify the concepts taught.

Part Two provides analyses of nursing situations in terms of social factors involved as a means of encouraging a broader understanding both of the patient's problems and community health needs. Community resources to meet such needs are presented as basic principles rather than specific agency programs. Thus the information is directly applicable to any community. This part of the book could be a valuable reference for clinical conferences, the study of community health organization or similar courses.

This could be recommended as a valuable source book for graduate nurses who have not had a course in sociology and who wish to improve their understanding of the world in which we live and work.

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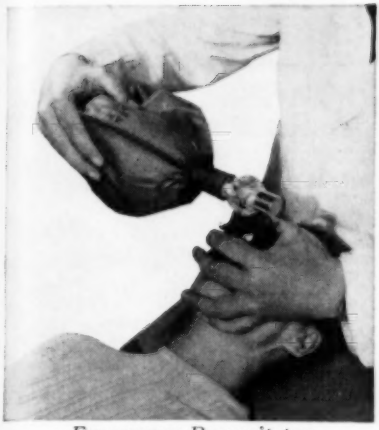

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* * *

A comprehensive annotated bibliography, consisting of over 300 references on staphylococcal infections, was featured in the December issue of the *American Journal of Nursing*. Culled from bacteriologic, medical, nursing, and public health literature, the list includes material which should be useful to anyone in the health field with an interest in setting and maintaining standards of asepsis.

A limited number of reprints of the section are available at a cost of 25 cents. Copies can be secured by writing to the *American Journal of Nursing*, 10 Columbus Circle, New York 19, N.Y.

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

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Registered Nurses for 100-bed active General Hospital. Good salary, personnel policies include 5-day work wk., 14-days paid sick leave accumulative, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan. Apply to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260, Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

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McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Staff Nurses (4) for convalescent area of 10-beds. Must rotate on all shifts, 8-hr. 5-day wk., good personnel policies, pension policy in effect., 3-wk. annual vacation, 8 statutory holidays. Salary open at present. Apply: Director of Nursing, General Hospital, Stratford, Ontario.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Nurses for 300-bed General Hospital,, basic salary $265 for days, with consideration given to postgraduate & equivalent experience, extra for shift work & call, 5-day wk. 3-wk. vacation after 1-year, 12 days sick leave per year. Apartments available near hospital. Apply to: Director of Nursing, St. Joseph's Hospital, **SARNIA,** Ontario.

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Registered Nurses (2) Certified Nursing Assistants. Salary $280-310 & $180-$210 respectively, 40-hr. wk., 1½-days sick leave per mo., 3-wk. paid vacation, transportation allowance, direct applications to: B. L. Ellis, Secretary, Union Hospital, Coronach, Saskatchewan.

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General Duty Nurses, combined Lab. - X-Ray Technician. Salary according to S.H.A. salary schedule & S.S.C.L.X.T. schedule. Apply to: The Matron, Bengough Union Hospital, Bengough, Saskatchewan.

Graduate Nurses for General Duty in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary effective January 1, 1960 $270 or $250 according to registration. 40-hr. wk., 3-wk. annual vacation, 8 statutory holidays, accumulative sick leave. Pension plan available. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Graduate Nurses (2) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 3-wk. vacation, plus statutory holidays, 40-hr. work week. Travel fare advanced if necessary. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses Surgery & General Duty for newly expanded 200-bed hospital located in Southern California. Starting salary $315 per mo. with $10 differential for obstetrics, surgery & night duty, 40-hr. wk. Progressive community near Disneyland. Contact: Director of Nurses, Miss E. F. Horton, Santa Ana Community Hospital, 600 East Washington Avenue, Santa Ana, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Staff Nurses (Openings on P.M. & night shifts) for 440-bed hospital. Starting salary $355 per mo. plus $25 differential. Tenure salary increases. Liberal vacation plan, 7 paid holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. For complete information write: Personnel Office, Sutter Community Hospitals, 2820 L Street, Sacramento, California.

Operating Room Nurses (2 Openings) for large General Hospital. Starting salary $380 per mo., plus $25 P.M. & night differential. Tenure salary increases. Liberal vacation plan, 7 paid holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write to Personnel Office, Sutter Community Hospitals, 2820 L Street, Sacramento, California.

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Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

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Registered Nurses for 85-bed voluntary non-profit hospital in growing community of 11,000. Basic salary $295 per mo. with increments of $5.00 every 6-mo. up to 2-years; 40-hr. wk.; 7 paid holidays, sick leave accumulative to 48-days; $17.50 premium for 3-11 shift, $15 additional for 11-7 shift. Apply to: Director of Nurses, St. John's Hospital of Red Wing, Red Wing, Minnesota.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

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Public Health Nurse (Qualified) for rural Health Unit in Alberta. Salary range from $3,300 - $3,780 with annual increment of $120, transportation is provided on duty, provision made for sick leave & holidays, pension plan is available. Apply to: Dr. K. A. Barrett, Medical Officer of Health, Minburn-Vermilion Health Unit, Vermilion, Alberta.

Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

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Registered Nurse — Salary $295 less maintenance, 44-hr. wk., excellent staff accommodation. 80-mi. west of Winnipeg on No. 1 highway. For further particulars apply to: Mrs. M. C. Roberts, Secretary, North Norfolk-MacGregor Medical Nursing Unit, MacGregor, Manitoba.

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Qualifications — Registered Nurse, supervisory experience.

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Orientation of nursing students and others to the department.

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Registered Nurses
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For further information write:

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Salary: $324 - $389 per month

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IMMEDIATELY. COMPETITION No. 59:152

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

NURSES FOR GENERAL DUTY IN ALL SERVICES.

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

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GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

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Gross salary $260 - $290 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
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